

00001

## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First <b>ADEN</b> Middle <b>AMBROSE</b> Last <b>ABE</b>			2a. DATE OF DEATH Month <b>JAN</b> Day <b>11</b> Year <b>68</b> 11:25 AM		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>2-1-28</b>	
7a. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Painter</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>	
13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>PIEDMONT AVE., EXT.</b>			
14. FATHER'S NAME First <b>CLAYTON</b> Middle <b>ABE</b> Last <b>ABE</b>			15. MOTHER'S MAIDEN NAME First <b>BERNICE</b> Middle <b>BUCKLEY</b> Last <b>BUCKLEY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>War II- 213-22-3524</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tracheal obstruction (distal)</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anaplastic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1992</b>					
19a. DATE OF OPERATION <b>1/2/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bronchoscopy</b>		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>29 Dec., 1967</b> , to <b>11 Jan., 1968</b> , that (I) (we) last saw the deceased alive on <b>11 Jan 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <del>did</del> <b>did not</b> view the body after death.					
22b. SIGNATURE <b>Andrew Stasko MD</b> DEGREE				22c. DATE SIGNED <b>1/11/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. ANDREW STASKO</b>				22e. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 14, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Abe Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Near Wiley Ford, W. Va.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 16 1968</b> DATE	
				25b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>	

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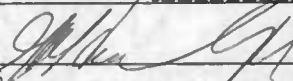

CLAYTON, N.Y.

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CLAYTON, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

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00002		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				00002	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <b>CATHERINE</b>			First Middle Last <b>T. ALKIRE</b>		2a. DATE OF DEATH <b>JAN. 26, 1968</b>		2b. HOUR <b>12:00</b>
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>8-14-1880</b>		6. AGE (In years last birthday) <b>87</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>HOLLIS</b>		First Middle Last <b>FLAGNER</b>		15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>216-22-6903</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4227</b> (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e) <b>Pneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>67</b> , to <b>Jan</b> , 19 <b>68</b> , that (I) <del>we</del> last saw the deceased alive on <b>Jan. 26</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> <del>(did not)</del> view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1-27-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>				22e. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan. 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Abe Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Nr Short Gap Mineral W. Va.</b>	
24. FUNERAL DIRECTOR <b>John J. Hafer, Jr.</b>		ADDRESS <b>230 Balto Ave Cumberland</b>		25a. REC'D BY REGISTRAR <b>JAN 29 1968</b>		25b. REGISTRAR'S SIGNATURE 	

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CLINICAL OF DEATH

1. CATHERINE J. ALBIRE JAN. 28, 1908 12:00

WHITE R-14-1800 87

CUMBERLAND, MD. U. S. A. X 1 ALLEGANY

CUMBERLAND, MD. MEMORIAL HOSPITAL - CUMBERLAND, MD.

ALLEGANY CUMBERLAND X 7 KING STREET

FLAMEY 12:12

MEMORIAL HOSPITAL - CUMBERLAND, MD. 12:12-12:15

General Hospital - Cumberland, Md.

General Hospital - Cumberland, Md.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00003						CERTIFICATE OF DEATH			00003		
1. DECEASED-NAME (Type or print)			First <b>LOTTIE</b>		Middle <b>Louise</b>	Last <b>ANSEL</b>		2a. DATE OF DEATH <b>JANUARY 1968</b>			2b. HOUR <b>5:00A</b>
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPT. 19, 1892</b>			6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.					
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>21 GRAND AVENUE</b>		
14. FATHER'S NAME First <b>WILLIAM</b>			Middle <b>SNYDER</b>		Last <b>FLORENCE</b>		15. MOTHER'S MAIDEN NAME First <b>V. BURKHART</b> Middle <b>V. BURKHART</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4200</b> (b) <b>Heart block</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterioscl. heart disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few weeks</b> <b>3-4 Mo.</b> <b>several years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Infected ulcer - Rt knee</b>											
19a. DATE OF OPERATION <b>Oct 1/67</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>face-maker, internal</b>				20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 20, 1967</b> to <b>Jan 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>Jan 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dr. A.J. Mirkin</b>						DEGREE <b>ATTENDING</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		22c. DATE SIGNED <b>1/3/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DR. A.J. MIRKIN</b>						22e. ADDRESS <b>115 SO. CENTRE STREET, CUMBERLAND, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>				23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JAN 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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LOTTE

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USA

CORRECTIONAL

ALLEGANY

WEST VIRGINIA

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WEST VIRGINIA

FLORANCE

GENERAL HOSPITAL, CORRECTIONAL, WEST VIRGINIA

ST. JAMES HOSPITAL

112 ST. CENTRE STREET, CORRECTIONAL

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## CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print) <b>Joseph B. Baker</b>			2a. DATE OF DEATH Month <b>Jan</b> Day <b>31</b> Year <b>1968</b>			2b. HOUR <b>7P.</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 4, 1891</b>		6. AGE (In years lost-birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.			
10. CITY OR TOWN OF DEATH <b>McCoole</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>R.D. 1 Westernport</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Miner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>McCoole</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>R.D. 1 Westernport</b>	
14. FATHER'S NAME First Middle Last <b>Joshua Baker</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Michaels</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>232-01-1277</b>		17. INFORMANT Address <b>Joseph M. Baker-R.D. 1, Westernport, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>410.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>422.1</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19____, to <b>Jan 31, 1968</b> , that (I) (we) last saw the deceased alive on <b>256-22-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert W. Bess</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-2-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Robert W. Bess</b>				22e. ADDRESS <b>Piedmont, W. Va.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/3/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sinclair</b>		23d. LOCATION (City or Town) (County) (State) <b>Cross-Mineral-W. Va.</b>			
24. FUNERAL DIRECTOR <b>E. F. Boral</b> ADDRESS <b>Westernport, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-2005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

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1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR							
James		Paul		Barnhill				1-7-68		6:00		P		M									
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year							
Male	White	Jan 7, 1886		80 YRS.		MONTHS		DAYS		January 7, 1968		6:30		P		M							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH															
Penna		U.S.A.		WIDOWED		DIVORCED		Allegany								Md.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY																	
LaVale		551 B <sup>n</sup> Street		Retired cement finisher																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER															
Maryland		Allegany		LaVale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		551 B Street															
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last									
James		P		Barnhill				Theresa						Donnelly									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
No		220-10-2251		Mrs. Wm E. Mitchell		551 B Street-LaVale, Md																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:																Sudden							
IMMEDIATE CAUSE (a) Coronary Occlusion																							
410.9 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																Coronary Sclerosis							
(b) DUE TO, OR AS A CONSEQUENCE OF																--							
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																							
4201																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?											
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
				HOUR A.M. P.M. 19																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County				State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				Benedict Skitarellic M.D.								CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				BENEDICT SKITARELIC, M.D.								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				January 7, 1968							
												ADDRESS (Street, city, town, or county)				Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)											
Burial				1-10-68				Rest Lawn Memorial Park				LaVale Allegany Maryland											
24. FUNERAL DIRECTOR								ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
H. Lee Silcox								Cumberland Maryland 21502				DATE JAN 11 1968				M. Lee Silcox							

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1-7-05 8:00 P

January 7, 1905 8:00 P

Station

Coroner's Collection

Coroner's Collection

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January 7, 1905

Quarantine

January 7, 1905

January 7, 1905



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00006										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										00006																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										M																																							
Bertha Beeman										Jan. 2nd. 1968																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Female										White										9/30/1885										82 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Maryland										USA.																				Allegany																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Frostburg										Miners Hospital										None																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																													
MD.										Allegany										Lonaconing										YES										Railroad St.																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
Martin Beeman										Rachael Ross																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT Address																																							
No										None										Mrs. Alex Rowe Frostburg, Md.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										(Neice)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) 486X										ACUTE BILATERAL PNEUMONITIS										6 days																																							
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)																																																	
DUE TO, OR AS A CONSEQUENCE OF										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										492X																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from Dec 27, 1967, to Jan 2, 1968, that (I) (we) last saw the deceased alive on Jan 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																													
A Paige Strong																														Jan 2, 1968																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
A Paige Strong										Frostburg, Md.																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										1/4/1968										Memorial Park										Frostburg, Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
George Eichhorn										Lonaconing, Md.										JAN 8 1968										Charles Judge																													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
00007										
1. DECEASED-NAME (Type or print) <b>MARION</b>			First Middle Last			2a. DATE OF DEATH Jan. Month 22nd. Year 1968		2b. HOUR M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 31st. 1879</b>		6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.				
10. CITY OR TOWN OF DEATH <b>Frostburg</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miners Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired telephone</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Operator</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Lonaconing</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME <b>Thomas Bell</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Margaret McMillian</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mary Stevens La Vale, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>4/2.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b> (Sister) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>6 mons</b> <b>years</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 22, 1958</b> , to <b>Jan 22, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Jan 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (ed) (did not) view the body after death.										
22b. SIGNATURE <b>L.R. Miles, Jr. M.D.</b>		22c. DATE SIGNED <b>1.23.68</b>			22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR, M.D.</b>					
22e. ADDRESS <b>LONA CONING MD.</b>		22f. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/25/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Lonaconing, Md.</b>			
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JAN 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			

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DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
00008 CERTIFICATE OF DEATH 00008									
1. DECEASED-NAME (Type or print) First Middle Last <b>HATTIE Rebecca BERGDOLL</b>					2a. DATE OF DEATH Month Day Year <b>JANUARY 16 1968</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>2-22-85</b>		6. AGE (In years lost birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b> Md.			
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housekeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>OLDTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT. 1 BOX 91</b>
14. FATHER'S NAME First Middle Last <b>HEZIKIAH SHOEMAKER</b>					15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY ALICE HINKLE</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Infarction</b> <b>433.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>332.8</b> (b) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 day</b> <b>5 year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes</b> <b>ventral hernia (umbilical)</b> <b>epitaphic obstruction</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>68</b> , to <b>1/16</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1/15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>1/18/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>					22e. ADDRESS <b>CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-19-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>N. Mill Creek</b>			23d. LOCATION (City or Town) (County) (State) <b>Dorcas, Grant, W. Va.</b>		
24. FUNERAL DIRECTOR <b>[Signature]</b> ADDRESS <b>Petersburg, W. Va.</b>				25a. REC'D BY REGISTRAR <b>[Signature]</b> DATE <b>JAN 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. TIME			
Charles Arlington Boden						M <input checked="" type="checkbox"/> Month Day Year			Jan. 10, '68 5:50 PM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	White	01/07/97	61 YRS.	MONTHS	DAYS	HOURS	MIN.	January 19, 1968			7:30 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
MARYLAND		U.S.A.				Allegany Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cumberland, Md.			Memorial Hospital--DOA			LABOR						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MD			ALLEGANY						LITTLE ORLEANS MD.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
DAVID BODEN			SUSIE						GARLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			18.03.2737			ELLEN H BODEN			44 MEADOW ST. CLYDE N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Multiple injuries and fractures										Sudden		
8147 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) (Struck by Auto)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
8124												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			5:50 P.M. 1-10-68			Struck by auto						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
			Street			Rt. 40 Near Wash. Co. Line, Alleg. Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			BENEDICT SKITARELIC, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			January 10, 1968			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)					
BURIAL			1.12.68		LITTLE ORLEANS		LITTLE ORLEANS ALLEGANY MD					
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard J. Stone						Hancock mol			DATE JAN 17 1968		Charles Judge	

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CHURCH ATTENTION: 1-10-52

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR M
( Baby )			Broadwater			1/10/1968			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/10/1968			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.			
10. CITY OR TOWN OF DEATH Frostburg			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Miners Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Allegany		13c. CITY OR TOWN Lonaconing	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Washington St.	
14. FATHER'S NAME First Middle Last Gerald Clinton Broadwater			15. MOTHER'S MAIDEN NAME First Middle Last Carol Williamson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Gerald Broadwater Lonaconing, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ateletthosis</u> (Father) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>776.9</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>762.0</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>762.0</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> , 19 <u>68</u> , to <u>1/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/10/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>J. S. Davis</u>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1/10/68</u>	
22d. PHYSICIAN'S NAME (Type) John Davis				22e. ADDRESS Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/11/1968		23c. NAME OF CEMETERY OR CREMATORY Wilhelm Cemetery			23d. LOCATION (City or Town) (County) (State) (Rural) Garrett Co. Md.		
24. FUNERAL DIRECTOR George Eichhorn Lonaconing, Md.						25a. REC'D BY REGISTRAR DATE JAN 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>Item 18</div> <div>397 2-9-MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>00011</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00011</div> </div>									
1. DECEASED-NAME (Type or Print)						2a. DATE KNOWN OF DEATH		2b. TIME	
First Middle Last						Month Day Year		PM	
Jane Bowen Bruce						Jan. 20, 1968		3:00	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Female	White	January 9, 1911	57 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year	PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Grantsville Md.		U.S.A.				Allegany Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cumberland			Memorial Hosp. DCA.			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany		Cumberland			223 Washington Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Ralph Bowen			Rose Callaghan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
					Robert Bruce 223 Washington Street				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									Minutes
IMMEDIATE CAUSE (a) Asphyxiation									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Aspiration of Stomach Contents									"
DUE TO, OR AS A CONSEQUENCE OF									
(c) Vomiting due to imbibing alcohol									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
3222									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Benedict Skitarelic				M.D.		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		January 23, 1968	
						ADDRESS (Street, city, town, or county)		Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Jan. 24, 68		SS. Peter & Paul Cemetery		Cumberland Allegany Md.			
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Louis Stein Inc.		Cumberland Md.				DATE JAN 25 1968		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																										
CERTIFICATE OF DEATH																										
00012																										
1. DECEASED-NAME (Type or print)			First MARY			Middle ANN			Last BURKE			2a. DATE OF DEATH Month JAN			Day 11			Year 68			2b. HOUR 1:15			P M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 5-1-76			6. AGE (In years lost birthday) 91			YRS.			IF UNDER 1 YEAR MONTHS			DAYS			IF UNDER 24 HRS. HOURS			MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY																	
10. CITY OR TOWN OF DEATH CUMBERLAND			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home																	
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 206 SEYMOUR ST.														
14. FATHER'S NAME First MICHAEL			Middle FAHERTY (FAHERTY)			Last (FAHERTY)			15. MOTHER'S MAIDEN NAME First MARY			Middle PENDERGAST			Last PENDERGAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 471x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>480x</u> (b) <u>Influenza</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic C.V. Disease</u>																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-31-1967</u> , to <u>1-11-1968</u> , that (I) (we) last saw the deceased alive on <u>1-11-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE <u>W. F. Williams</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 1-13-68											
22d. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			22e. ADDRESS CUMBERLAND, MD.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Jan. 15, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany																	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.						ADDRESS			25a. REGD. BY REGISTRAR DATE JAN 16 1968			25b. REGISTRAR'S SIGNATURE <u>James F. Scarpelli</u>														

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EVALUATION OF THE EFFECTS OF

CUMBERLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
00013					00013						
1. DECEASED-NAME (Type or print)					First		Middle		Last		
WILLIAM					NMI		BYERS				
2. DATE OF DEATH					Month		Day		Year		
JAN.					5,		1968		8:00PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)		
MALE			WHITE			JANUARY 12, 1908			59 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			USA						ALLEGANY Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND, MD.			SACRED HEART HOSP.			CLERK			ACME MKT.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND			ALLEGANY			BARTON					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
WILLIAM BYERS			MARJORIE BOGIE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
NO			216-07-2750			HOSPITAL RECORD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Metastatic carcinoma to</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Liver from rectum</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a))											
154 X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
5-28-65			Cancer rectum			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
			HOUR A.M. Month Day Year P.M.								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-</i> , 1968, to <i>1-5-</i> , 1968, that (I) (we) last saw the deceased alive on <i>1-5-</i> , 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
<i>Earl R. Paul M.D.</i>			1-6-68								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
EARL R. PAUL, M.D.			36 GREENE ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			1/8/1968			Laurel Hill Cemetery			Moscow, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REG'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
George Eichhorn			Lonaconing, Md.			JAN 11 1968			<i>Charles Judge</i>		

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WILLIAM WHITE 1900 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last MORRIS M CODDINGTON					01 Month 27 Day 68 Year			3:30 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 05-20-89		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) FRIENDSVILLE, MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY Md.			
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARM		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA.		13b. COUNTY ADDISON		13c. CITY OR TOWN ADDISON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ROUTE #1	
14. FATHER'S NAME First Middle Last MELVILLE CODDINGTON			15. MOTHER'S MAIDEN NAME First Middle Last MARTHA LANCASTER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address HOSPITAL RECORD, 900 SETON DRIVE, CUMB., M D.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> 440.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4500									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-7</u> , 19 <u>68</u> , to <u>1-27</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>1-27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>was seen by Dr. Ken Key</u>									
22b. SIGNATURE <u>L. Brings</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>1-28-68</u>			
22d. PHYSICIAN'S NAME (Type) KEWIS BRINGS, M.D.				22e. ADDRESS 57 GREENE STREET, CUMB., M D. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 31, 68		23c. NAME OF CEMETERY OR CREMATORY Addison		23d. LOCATION (City or Town) (County) (State) Addison Seneca P.			
24. FUNERAL DIRECTOR <u>Luzh Newman, Grantville, Md.</u>				25a. REC'D BY REGISTRAR DATE FEB 2 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |   |   |  |   |  |  |  |  |  |
|--|--|--|---|---|--|---|--|--|--|--|--|
| 00015  |  |  | 00015   |   |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>GLADYS NELLIE COFFMAN</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>JAN</b> Day <b>17</b> Year <b>68</b>                  |   |  | 2b. HOUR <b>10:10</b> MIN <b>A</b>  |  |  |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br><b>6-26-04</b>  |  | 6. AGE (In years last birthday)<br><b>63</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>     |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>ALTAMONT, MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  | 13b. COUNTY<br><b>ALLEGANY</b>   |   | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>509 HILLTOP DRIVE</b> |  |  |  |
| 14. FATHER'S NAME<br>First <b>EVAN</b> Middle <b>MATHEWS</b> Last <b>BERTHA</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>BERTHA</b> Middle <b>E.</b> Last <b>MARTIN</b> |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>213-18-2933</b>   |   | 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>   |  | Address<br><b>CUMBERLAND, MD.</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4129 Congestive heart failure on</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201 Basis of coronary artery disease (over)</b><br>(b) <b>4201</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4201</b> |  |  |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus (Bleed)</b>  |  |  |   |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-16-67</b> , to <b>1-17-68</b> , that (I) (we) last saw the deceased alive on <b>1-17-68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Wm. F. Williams</b>   |  | DEGREE<br><b>MD.</b>   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>1-17-68</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. W. F. WILLIAMS</b>  |  | 22e. ADDRESS<br><b>CUMBERLAND, MD.</b>   |   |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/20/1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Near Cumberland Alleg Md.</b>               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Bafer, Jr.</b>  |  | ADDRESS<br><b>290 Balto Ave. Cumberland</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 22 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Bafer, Jr.</b>   |  |  |  |  |  |

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DR. A. T. WILLIAMS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>EMMA</b>  |  |  | First <b>E</b> Middle <b>E</b> Last <b>COOK</b>  |   |   | 2a. DATE OF DEATH<br>Month <b>JAN</b> Day <b>30</b> Year <b>68</b>  |  | 2b. HOUR<br><b>9:12A</b> M  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>2-22-09</b>  |   | 6. AGE (In years last birthday)<br><b>58</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>58</b> DAYS <b>58</b> HOURS <b>58</b> MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENNA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>PENNA.</b>  |  | 13b. COUNTY<br><b>GLENCREE</b>   |  | 13c. CITY OR TOWN<br><b>GLENCREE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>BOX 38</b>                                 |  |
| 14. FATHER'S NAME<br>First <b>EZRA</b> Middle <b>E</b> Last <b>FUNK</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>SARAH</b> Middle <b>ZIMMERMAN</b> Last <b>ZIMMERMAN</b> |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>   |   | Address<br><b>CUMBERLAND, MD.</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br><b>394.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>410X</b><br>(b) <b>Various Arrhythmias</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Mitral Stenosis and Insufficiency; Tricuspid Stenosis?</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>16 hrs.</b><br><b>3 Wks prior to admission</b> |  |  |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Carcinoma of Rectum</b> and Insufficiency   |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>1/29/68</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Rectum</b>                           |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                        |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b> |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/22/1967</b> , to <b>1/30/1968</b> , that (I) (we) last saw the deceased alive on <b>1/30/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>DR. SAMUEL M. JACOBSON</b>  |  |  |  | DEGREE<br><b>MD.</b>  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-31-68</b>                                      |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. SAMUEL M. JACOBSON</b>  |  |  |  | 22e. ADDRESS<br><b>CUMBERLAND, MD.</b>  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>Feb 2, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Lebanon</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Northampton Township Somerset Co. Pa.</b>                                   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Halter A. Johnson</b>   |  |  |  | ADDRESS<br><b>Berlin, Pa</b>  |   | 25a. REC'D BY REGISTRAR<br><b>EEB</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                      |  |
|  |  |  |  | DATE<br><b>5 1968</b>   |   |   |  |   |  |

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DR. JAMES M. JACOBSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |   |  |  |                                    |  |
|--|--|--|--|--|--|--|--|--|---|--|--|------------------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |   |  |  |                                    |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>JULIA</b>  |  |  | Middle<br><b>CORfield</b>  |  |  | Last  |  |  |                                    |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>3/23/1889</b>   |  |  | 6. AGE (In years last birthday)<br><b>1888 79 79 YRS.</b>                                       |  |  |                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Lonaconing</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. COUNTY OF DEATH<br><b>Allegany</b>   |  |  |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rrostburg</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Miners Hospital</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>Allegany</b>   |  |  | 13c. CITY OR TOWN<br><b>Lonaconing</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |  |                                    |  |
| 14. FATHER'S NAME<br><b>Louis Marks</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Margaret Kolmer</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-20-5061</b>  |  |  |                                    |  |
| 17. INFORMANT<br><b>Irene Wilson</b>   |  |  | Address<br><b>Lonaconing, Md.</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic CVD disease</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>14 days</b><br><b>years</b> |  |  |                                    |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                      |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |   |  |  |                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1968</b> to <b>Jan 20 1968</b> , that (I) (we) last saw the deceased alive on <b>Jan 19 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |   | 22b. SIGNATURE<br><b>L.R. MILES, JR., M.D.</b> |  | 22c. DATE SIGNED<br><b>1-22-68</b> |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>L.R. MILES, JR., M.D.</b>   |  |  | 22e. ADDRESS<br><b>LONACONING MD.</b>  |  |  | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |  |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>1/22/1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Lonaconing, Md.</b>                         |  |  |                                    |  |
| 24. FUNERAL DIRECTOR<br><b>George Eichhorn</b>   |  |  | ADDRESS<br><b>Lonaconing, Md.</b>  |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 23 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |                                    |  |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |         |  |        |  |                   |  |          |  |
|--|---------|--|--------|--|-------------------|--|----------|--|
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| 1. DECEASED-NAME (Type or print)   |         | First  | Middle | Last   | 2a. DATE OF DEATH |  | 2b. HOUR |  |
| CRAZE, ROY THOMAS  |         |  |        |  | Month             | Day  | Year     | 68 5:29                                      |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)  |                   | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS.                             |
| MALE   | WHITE   | 11-26-12   |        | 55 YRS.  |                   | MONTHS   | DAYS     | HOURS MIN                                    |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH   |          |  |
| MARYLAND   |         | U.S.A.   |        |  |                   | ALLEGANY COUNTY Md.  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give a post address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                   | 12b. KIND OF BUSINESS OR INDUSTRY  |          |  |
| CUMBERLAND   |         | SACRED HEART HOSPITAL  |        | SPINNING DEPT.   |                   | CELANESE CO.   |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          | 13e. STREET AND NUMBER                       |
| MARYLAND   |         | ALLEGANY   |        | CUMBERLAND   |                   |  |          | 601 HENDERSON AVENUE                         |
| 14. FATHER'S NAME  |         | Last   |        | 15. MOTHER'S M maiden NAME First   |                   | Middle   |          |  |
| Roy THOMAS   |         | CRAZE  |        | STUBER EDITH   |                   | Schuyler   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown   |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |                   | Address  |          |  |
| YES  |         |  |        | HOSPITAL RECORD  |                   | 900 SETON DRIVE CUMB., MD. 21502   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |        |  |                   |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:   |         |  |        |  |                   |  |          |  |
| IMMEDIATE CAUSE (a) <u>Massive G I Bleeding</u>  |         |  |        |  |                   |  |          | <u>10 days</u>                               |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |  |                   |  |          |  |
| (b) <u>Diffuse hemorrhagic gastritis</u>   |         |  |        |  |                   |  |          |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |  |                   |  |          |  |
| (c) <u>Bilateral pneumonia</u>   |         |  |        |  |                   |  |          | <u>3 days</u>                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |         |  |        |  |                   |  |          |  |
| 543X   |         |  |        |  |                   |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY?  |                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |          |  |
| 1/25/68  |         | Hemorrhagic gastritis  |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                   |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |                   |  |          |  |
|  |         |  |        |  |                   |  |          |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                   |  |          |  |
|  |         |  |        |  |                   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> , 19 <u>68</u> , to <u>1/31</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>1/31</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did not)</u> view the body after death. |         |  |        |  |                   |  |          |  |
| 22b. SIGNATURE   |         |  |        | DEGREE   |                   | ATTENDING PHYS.  |          | 22c. DATE SIGNED                             |
| <u>Andrew Staskom</u>  |         |  |        |  |                   | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.       |          | <u>2/1/68</u>                                |
| 22d. PHYSICIAN'S NAME (Type)   |         |  |        | 22e. ADDRESS   |                   |  |          |  |
|  |         |  |        |  |                   |  |          |  |
| 23a. BURIAL, CREMATION, or other (Specify)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)  |          |  |
| <u>Burial</u>  |         | <u>2/2/68</u>  |        | <u>Restlawn memo. Ph.</u>  |                   | <u>Cumberland Md.</u>  |          |  |
| 24. FUNERAL DIRECTOR   |         |  |        | 25a. REC'D BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |          |  |
| <u>Louis Stein</u>   |         |  |        | DATE <u>FEB 5 1968</u>   |                   | <u>Charles Jones</u>   |          |  |
| STEIN FUNERAL HOME-117 FREDERICK ST., CUMB.  |         |  |        |  |                   |  |          |  |

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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STEINERMAN, HENRY - 117 BROOKLYN ST., CUM.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00019

|  |  |  |  |   |   |  |  |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>ROBERT</b>   | Middle<br><b>UDELL</b>  | Lost<br><b>CRITES</b>                     | 20. DATE OF DEATH<br>Month <b>JAN</b> Day <b>22</b> Year <b>68</b>   |  |  | 2b. HOUR <b>1:50</b> P                                       |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>4-25-09</b>  |   | 6. AGE (In years last birthday)<br><b>58</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>W. VA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Brakeman</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O. Rwy.</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>ALLEGANY</b>   |   | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>    |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>North Branch RT. 4, BOX 245</b> |  |  |
| 14. FATHER'S NAME<br>First <b>JESSE</b> Middle <b>G.</b> Lost <b>CRITES</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>FLORENCE</b> Middle <b>WEESE</b> Lost <b>WEESE</b>                  |   |   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b> |  |  | Address<br><b>CUMBERLAND, MD.</b>                                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b><br><b>571.0</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cirrhosis of the liver &amp; ascites and Esophageal bleeding</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic alcohol intake</b> |  |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>5811</b>   |  |  |  |   |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1968</b> , to <b>22 Jan</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>22 Jan</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Carlton Brinsfield</b>  |  | DEGREE   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |   | 22c. DATE SIGNED<br><b>1-23-68</b>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. CARLTON BRINSFIELD</b>  |  | 22e. ADDRESS<br><b>CUMBERLAND, MD.</b>                                       |  |   |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/25/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Davis Memorial Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Allegany Md.</b>                           |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H. Wayne George</b><br>ADDRESS<br><b>Cumberland, Md.</b>  |  |  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 29 1968</b><br>DATE  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |  |

00019

00019

ROBERT WOOD CRITER JAN 22 08:00

NAME

WHITE

1-22-09

ALLIANCE

U.S.A.

W.VA.

CUMBERLAND

MEMORIAL HOSPITAL

1-22-09

ALLIANCE MEMORIAL HOSPITAL

NO.

FLORENCE

CRITER

1-22-09

MEMORIAL HOSPITAL

CUMBERLAND

DR. CARLTON BRINSFIELD

CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00020

CERTIFICATE OF DEATH

00020

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  | c. LENGTH OF STAY IN 1b<br><b>10 DAYS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>  |  | d. STREET ADDRESS<br><b>BOX 490 VALLEY RS.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CLARENCE</b> Middle <b>B.</b> Last <b>DAVIS</b>   |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>5</b> Year <b>19 68</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>APRIL 16, 1895</b>                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>JANITOR</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CELANESE</b>  | 9. AGE (In years lost birthday) yrs.<br><b>72</b>                         |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>WEST VA.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>CHARLES DAVIS</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY E. FELLERS</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES</b>   |  | 16. SOCIAL SECURITY NO.<br><b>216-18-1253</b>   |   |
| 17. INFORMANT<br><b>HOSPITAL RECORD</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>412.9 UREMIC POISONING</b><br>IMMEDIATE CAUSE (a) DUE TO<br><b>ARTERIOSCLEROTIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>420.0</b> (b) DUE TO<br><b>CONGESTIVE HEART FAILURE</b><br>(c) |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>DIABETES MELLITUS- GENERALIZED ARTERIOSCLEROSIS</b>   |  |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> #  |  | INTERVAL BETWEEN DEATH<br><b>25 MO.</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>NONE</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour: a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, street, office bldg., etc.)<br><b>NONE</b>  | 20f. (City or town) (County) (State)<br><b>FEB. 14, 63 JAN. 5, 68</b>     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 5, 19 68</b> , that (I) (we) last saw the deceased alive on <b>JAN. 5, 19 68</b> , and that death occurred at <b>12:05 AM</b> , from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><i>James P. Hallinan M.D.</i>   |  | 22b. DATE SIGNED<br><b>1-5-68</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JAMES P. HALLINAN, M.D.</b>  |  | 22d. ADDRESS<br><b>140 BEDFORD ST., CUMBERLAND, MD.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>Jan. 8, 1968</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Porter Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hyndman, Pa. RD#1</b> |
| 24. FUNERAL DIRECTOR<br><b>Harvey H. Zeigler, Hyndman, Pennsylvania</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 8 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                        |

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ALLGARY

ALLGARY

ALLGARY

CUMBERLAND

10 DAYS

CUMBERLAND

BOX 400 VALLEY ST.

SACRED HEART HOSPITAL

JANUARY 2

DAVIS

B.

CLARENCE

X

APRIL 16, 1902

WHITE

WHITE

USA

WEST VA.

CHINESE

JANITOR

MARY E. FELLERS

CHARLES DAVIS

216-1-1253 HOSPITAL RECORD

YES

GREY POISONING

ARTERIOSCLEROTIC HEART DISEASE

CONGESTIVE HEART FAILURE

DIABETES MELLITUS - GENERALIZED ARTERIOSCLEROSIS

HOME

HOME

FEB. 14,

JAN. 2,

JAN. 2,

140 BEDFORD ST., CUMBERLAND, MD.

JAMES F. HOLLAND, M.D.



00021

## CERTIFICATE OF DEATH

00021

|   |  |  |  |   |  |  |   |   |  |  |  |
|---|--|--|--|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>WILLIAM A. DAWSON</b>   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 19, 1968</b>   |   |  | 2b. HOUR<br><b>5:00</b>  |   |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>OCT. 1, 1896</b>   |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.  |   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired brakeman</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>ALLEGANY</b>   |   | 13c. CITY OR TOWN<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER<br><b>217 GLENN STREET,</b> |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>ALEX DAWSON</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>JO HARETT JONES.</b>                                 |   |  |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>Yes</b> War <b>I</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>                                  |  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left Cerebral Hemorrhage</b><br><b>4319</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Right Hemiplegia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b> |  |  |  |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>10 days</b><br><b>2 hrs</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>331X</b>  |  |  |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>                            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                                    |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1968</b> , to <b>Jan 19, 1968</b> , that (I) (we) lost the deceased alive on <b>Jan 18, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Clay E. Durrett</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br><b>1/19/68</b>   |   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. CLAY E. DURRETT</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE<br><b>Jan. 22, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>                                      |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JAN 23 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>                            |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00031

00031

CENTRAL DE DEATH

JANUARY 19, 1966 2:00

DANSON

A.

WILLIAM

WHITE

WALL

DET. 1, 1966

X

ALLEGANY

W. S. 1.

CUMBERLAND

MEMORIAL HOSPITAL

HARRY AND ALLEGANY

317 B. L. R. STREET

SEX

DANSON

HARVEY

JONES

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. CLAY E. DURRETT

338 VIRGINIA AVE., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>THOMAS  |  | Middle<br>CLINTON   |  | Last<br>DEALE   |  | 2a. DATE OF DEATH<br>Month<br>JANUARY                                   |  | 2b. HOUR<br>Day<br>12<br>Year<br>1968<br>12:45 M  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MARCH 12, 1889  |  | 6. AGE (In years<br>last birthday)<br>78 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                       |  | IF UNDER 24 HRS<br>HOURS<br>MIN   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>VIRGINIA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>ALLEGANY Md.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>RETIRED   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>B & O RR  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND  |  | 13b. COUNTY<br>ALLEGANY  |  | 13c. CITY OR TOWN<br>CUMBERLAND   |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>413 OLDTOWN ROAD, CITY                        |  |   |  |
| 14. FATHER'S NAME<br>First<br>SILAS   |  | Middle<br>B.   |  | Last<br>DEALE   |  | 15. MOTHER'S MAIDEN NAME<br>First<br>ELIZABETH  |  | Middle<br>BERRY   |  | Last<br>BERRY   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>NO   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Address<br>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND                         |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u><br><u>2509</u> DUE TO, OR AS A CONSEQUENCE OF <u>Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u><br>(c) <u>Myocarditis</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><u>260x</u> |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>7 yrs</u><br><u>6 mos</u><br><u>6 mos</u> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                      |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |  | State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 6, 1968</u> , to <u>Mar 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>Mar 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Clay E. Durrett</u>  |  | DEGREE<br>ATTENDING PHYS.  |  | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.  |  | 22c. DATE SIGNED<br><u>3/12/68</u>  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DR. CLAY E. DURRETT   |  | 22e. ADDRESS<br>236 VIRGINIA AVENUE, CUMB., MD.  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>1/14/1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CAMP HILL CEMETERY  |  | 23d. LOCATION (City or Town)<br>NEAR PAW PAW, WEST VIRGINIA                                 |  | (County)<br>WEST VIRGINIA   |  | (State)   |  |
| 24. FUNERAL DIRECTOR<br>JOHN J. HAFFER, JR.   |  | 24a. REC'D BY REGISTRAR<br>JAN 17 1968   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |   |  |   |  |

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JANUARY 12 1989

DEATH

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330 VIRGINIA AVE, CINCINNATI, OH

DR. CLAY E. GURNEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|  |  |  |   |   |  |   |   |  |   |  |  |
|--|--|--|---|---|--|---|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MICHAEL</b>   |  |  | First <b>J.</b>   | Middle  | Last <b>FAHEY</b>                              | 2a. DATE OF DEATH<br><b>01</b> Month <b>21</b> Day <b>68</b> Year   |   |  | 2b. HOUR<br><b>12:30</b>                            |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br><b>10-10-97</b>   |  | 6. AGE (In years last birthday)<br><b>70</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |   | IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b>   |   |  | Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SACRED HEART</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>MACHINIST HELPER</b>                        |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>TEXTILE</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>ALLEGANY</b>  |   | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>         |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>123 HANOVER ST.</b>    |  |  |
| 14. FATHER'S NAME<br><b>JOHN</b>   |  |  | First   | Middle  | Last <b>FAHEY</b>                              | 15. MOTHER'S MAIDEN NAME<br><b>MARGARET</b>   |   |  | Middle  | Last <b>CARNEY</b>                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>YES</b>  |  |  | (If yes, give year or dates of service)<br><b>1942-3</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>217-14-5626</b> |   | 17. INFORMANT<br><b>HOSPITAL RECORD</b>   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br><b>486x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>493x</b><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12/5/68</b>       |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Diabetes Essential Hypertension</b>   |  |  |   |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County   |   | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , to <b>1/21</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1/25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |   |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>S. G. WEISMAN</b>   |  |  |   |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/21/68</b>                                   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>S. G. WEISMAN M.D.</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>59 GREEN ST., CUMBERLAND, MD.</b>  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>JAN. 24, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. PATRICKS CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>CUMBERLAND ALLEGANY MD.</b>   |   |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>KIGHT'S FUNERAL HOME</b>  |  |  |   |   |  | BYRON KIGHT<br>ADDRESS<br><b>CUMBERLAND, MD.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 24 1968</b>                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00024

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00024

|  |         |  |  |   |  |   |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
|--|---------|--|--|---|--|---|--|--|--|--------------------------|--|------------------|--|------------------|--|-----------------------|--|---------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  |  | Middle  |  | Last  |  | 2a. DATE KNOWN OF DEATH                      |  | ESTIMATED                |  | Month            |  | Day              |  | Year                  |  | 2b. HOUR            |  |
| LILLIAN  |         |  |  | FELDMAN   |  |   |  | 1-26   |  | 1968                     |  | 4:00 P.M.        |  |                  |  |                       |  |                     |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                             |  | 2c. DATE PRONOUNCED DEAD |  | Month            |  | Day              |  | Year                  |  | 2d. HOUR            |  |
| FEMALE   | WHITE   | 6-28-1882  |  | 85 YRS.   |  | MONTHS  |  | DAYS   |  | 1                        |  | 26               |  | 1968             |  | 5:00 P.M.             |  |                     |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH                           |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| ALLEGANY   |         | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  | ALLEGANY                                     |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| ECKHART  |         |  |  | HOUSE WORK  |  | OWN HOME  |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE                                      |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                       |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| MD.  |         | ALLEGANY   |  | ECKHART   |  | YES   |  | NO   |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 14. FATHER'S NAME  |         | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME                     |  | First                    |  | Middle           |  | Last             |  |                       |  |                     |  |
| PETER FELDMAN  |         |  |  |   |  |   |  | MARY FARLEY                                  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
|  |         |  |  | MISS MARY FELDMAN, ECKHART, MD.   |  |   |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | Coronary Occlusion  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | Sudden                   |  |                  |  |                  |  |                       |  |                     |  |
| 4109   |         | DUE TO, OR AS A CONSEQUENCE OF   |  | (b)   |  | Coronary Sclerosis  |  | --   |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                     |         | DUE TO, OR AS A CONSEQUENCE OF   |  | (c)   |  |   |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |         | 4201   |  |   |  |   |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  | 20. AUTOPSY?  |  | YES   |  | NO   |  | X                        |  |                  |  |                  |  |                       |  |                     |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY  |         | OR CONTRIBUTING  |  | 21b. TIME OF INJURY Month, Day, Year  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| CAUSE OF DEATH   |         |  |  | HOUR A.M.   |  | P.M.  |  | 19   |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 21d. INJURY OCCURRED WHILE AT WORK   |         | NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)            |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town                                 |  | County                   |  | State            |  |                  |  |                       |  |                     |  |
| 22a. I certify that I took charge of the remains described above, held an  |         | Autopsy  |  | Inspection  |  | Inquiry   |  | and in my opinion death resulted from:       |  | Natural causes           |  | Accident         |  | Suicide          |  | Homicide              |  | Undetermined manner |  |
| X  |         | X  |  | X   |  |   |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| ACTUAL SIGNATURE   |         | Benedict Skitarelic  |  | M.D.  |  | CHIEF MEDICAL EXAMINER  |  | ASSISTANT MEDICAL EXAMINER                   |  | DEPUTY MEDICAL EXAMINER  |  | 22b. DATE SIGNED |  | January 26, 1968 |  | RD 9, Cumberland, Md. |  |                     |  |
| EXAMINER'S NAME (Type)   |         | BENEDICT SKITARELIC, M. D.   |  |   |  |   |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)                                     |  | (State)                  |  |                  |  |                  |  |                       |  |                     |  |
| BURIAL   |         | JAN. 29, 1968  |  | ST. MICHAELS CEMETERY   |  | FROSTBURG, MD.  |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| 24. FUNERAL DIRECTOR   |         | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                          |  |                  |  |                  |  |                       |  |                     |  |
| JOSEPH R. DURST, FROSTBURG, MD.  |         | 21532  |  | DATE  |  | FEB 1 1968  |  | Charles Judge                                |  |                          |  |                  |  |                  |  |                       |  |                     |  |

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|                                 |  |                                     |  |                   |  |
|---------------------------------|--|-------------------------------------|--|-------------------|--|
| NAME                            |  | DATE                                |  | TIME              |  |
| LAST                            |  | FIRST                               |  | MIDDLE            |  |
| SUFFIX                          |  | INITIALS                            |  | DATE OF BIRTH     |  |
| PLACE OF BIRTH                  |  | CITY                                |  | STATE             |  |
| COUNTRY                         |  | ZIP CODE                            |  | TELEPHONE         |  |
| EDUCATION                       |  | OCCUPATION                          |  | EMPLOYER          |  |
| MARRIAGE                        |  | DIVORCE                             |  | DEATH             |  |
| MILITARY                        |  | NAVY                                |  | ARMY              |  |
| AIR FORCE                       |  | MARINE                              |  | COAST GUARD       |  |
| OTHER                           |  | REMARKS                             |  | SIGNATURE         |  |
| OFFICIAL                        |  | TITLE                               |  | DATE              |  |
| FEDERAL BUREAU OF INVESTIGATION |  | UNITED STATES DEPARTMENT OF JUSTICE |  | WASHINGTON, D. C. |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00025

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00025

|   |  |  |  |   |   |   |   |  |  |  |  |
|---|--|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Charles</b>   |  |  | First Middle Last<br><b>Filer</b>  |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>January 16, 1968</b>  |   |  | 2b. HOUR<br><b>11:30 A.M.</b>  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>6/13/1880</b>  |   |   | 6. AGE (In years last birthday)<br><b>87</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br><b>Allegany</b> Md.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Allegany County Infirmary</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired: Coal Miner</b>                                     |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Coal Mining</b>                      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Allegany</b>   |   | 13c. CITY OR TOWN<br><b>Frostburg</b>                                   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>85 Frost Avenue</b>                             |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>William A. Filer</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Frances Prichard</b>   |   |   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>208-05 4282-A</b>   |   | 17. INFORMANT<br><b>P.O.Box 599, Allegany County Infirmary records.</b> |   |   | Address<br><b>Cumberland, Md.</b>                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4409</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Gas Asphyxiation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Gas Asphyxiation</b> |  |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>14 days</b><br><b>yes</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4500</b>  |  |  |  |   |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 4, 1967</b> , to <b>Jan. 16, 1968</b> , that (I) (we) last saw the deceased alive on <b>Jan. 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>George M. Simmons</b>  |  |  |  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>G.M. Simmons</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>Memorial Hospital, Cumberland, Md.</b>   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 19 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fbg. Memorial Park</b>   |   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Frostburg, Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph R. Durst, Frostburg, Md. 21532</b>  |  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 22 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |  |  |                        |  |
|---|--|--|--|---|---|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |  |                        |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |                        |  |
| 00026   |  |  |  |   |   |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |  | 2b. HOUR                                     |                        |  |
| THEODORE  |  |  | R. FLEEK   |   |   | Month Day Year<br>JAN 20 68   |  | 7:30 A M                                     |                        |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |                        |  |
| MALE  |  | WHITE  |  | 1-9-5   |   | 63 YRS.   |  |  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |  |                        |  |
| GRAFTON, W. VA.   |  | U.S.A.   |  |   |   | ALLEGANY Md.  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                        |  |
| CUMBERLAND  |  |  | MEMORIAL HOSPITAL  |   |   |   |  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| MARYLAND  |  |  | ALLEGANY   |   | CUMBERLAND  |   |  |  | 1201 LEXINGTON AVENUE  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |  |                        |  |
| First Middle Last   |  |  | First Middle Last  |   |   |   |  |  |                        |  |
| THEODORE FLEEK  |  |  | MARGARET MILLER  |   |   |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |   | Address  |  |                        |  |
|   |  |  | 235-14-2085  |   | MEMORIAL HOSPITAL   |   | CUMBERLAND, MD.  |  |                        |  |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |   |   |  |  |                        |  |
| IMMEDIATE CAUSE (a) <i>Carcinomatosis from</i>  |  |  |  |   |   |   |  | <i>4 months</i>                              |                        |  |
| 1533 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |  |  |                        |  |
| (b) <i>Adenocarcinoma of Sigmoid Colon</i>  |  |  |  |   |   |   |  | <i>10 months</i>                             |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |   |  |  |                        |  |
| (c)   |  |  |  |   |   |   |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |   |   |  |  |                        |  |
| 1533  |  |  |  |   |   |   |  |  |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
|   |  |  |  |   |   |   |  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |   |  |  |                        |  |
|   |  |  |  |   |   |   |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |                        |  |
|   |  |  |  |   |   |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> , 1968, to <i>1/20</i> , 1968, that (I) (we) last saw the deceased alive on <i>1/19</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |                        |  |
| 22b. SIGNATURE <i>Thomas F. Lewis M.D.</i>  |  |  |  |   | DEGREE  |   | 22c. DATE SIGNED <i>1/21/68</i>  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   | 22e. ADDRESS  |   |  |  |                        |  |
| DR. THOMAS F. LEWIS   |  |  |  |   | CUMBERLAND, MD.   |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| Burial  |  | Jan. 22, 1968  |  | Davis Memorial Cemetery   |   | Cumberland Allegany, Md.  |  |  |                        |  |
| 24. FUNERAL DIRECTOR <i>James F. Scarpelli, Cumberland, Md.</i>   |  |  |  |   | 25a. REC'D BY REGISTRAR DATE <i>JAN 23 1968</i>                                   |   | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>  |  |                        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00027

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00027

|   |  |  |   |   |  |  |   |  |   |   |  |
|---|--|--|---|---|--|--|---|--|---|---|--|
| 1. DECEASED-NAME (Type or print)<br>First Middle Last<br><b>Paul M. Fletcher</b>  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>January 22 1968</b>   |   |  | 2b. HOUR<br>M<br><b>M</b>  |   |  |   |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>June 13, 1905</b>  |  | 6. AGE (In years last birthday)<br><b>62</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>0 0</b>                         |   | IF UNDER 24 HRS.<br>HOURS MIN<br><b>0 0</b>   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Allegany</b> Md.  |   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>County Infirmary</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Attorney</b>                             |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Law</b>     |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Allegany</b>  |   | 13c. CITY OR TOWN<br><b>Cumberland</b>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>801 Ridgedale Ave.</b> |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Daniel A. Fletcher</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Julia Barnard</b>                                      |   |  |  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>Unknown</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>  |   | 17. INFORMANT Address<br><b>Gertrude Fletcher 801 Ridgedale Ave.</b> |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebrovascular accident, probably thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Chronic brain syndrome</b><br>(b) <b>Generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized arteriosclerosis</b> |  |  |   |   |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hours</b><br><b>Dec. 1961</b><br><b>???</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>Aneurysm, abdominal aorta, large, December, 1963</b>   |  |  |   |   |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>30 December 19 59</b> , to <b>22 January 19 68</b> , that (I) (we) last saw the deceased alive on <b>21 January 19 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.                             |  |  |   |   |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><b>W. A. Van Ormer</b>  |  |  |   |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>22 January 1968</b>                           |   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>W. Alfred Van Ormer, M. D.</b>   |  |  |   |   |  | 22e. ADDRESS<br><b>122 S. Centre St., Cumberland, Md. 21502</b>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>January 24/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Maryland</b>   |   |  |   |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Louis Stern Inc. Cumb. Md.</b>   |  |  |   |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 25 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |   |   |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00028

|   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|------------------|--|--|----------------|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |  |  | First<br>ELIZABETH   |  |  | Middle<br>MAY   |  |  | Last<br>FLOWERS   |  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month Day Year |  |  | 2b. HOUR  |  |  |                  |  |  |                |  |  |
| 3. SEX<br>FEMALE  |  |  | 4. RACE<br>WHITE   |  |  | 5. DATE OF BIRTH<br>OCT 18, 1880  |  |  | 6. AGE (In years<br>last birthday)<br>87 88 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year                      |  |  | 2d. HOUR         |  |  |                |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>PENNSYLVANIA  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>ALLEGANY  |  |  |  |  |  | Md.   |  |  |                  |  |  |                |  |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>334 NORTH MECHANIC STREET |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>HOME  |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>ALLEGANY  |  |  | 13c. CITY OR TOWN<br>CUMBERLAND   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>334 NORTH MECHANIC STREET  |  |  |   |  |  |                  |  |  |                |  |  |
| 14. FATHER'S NAME<br>Jeremiah   |  |  | First<br>Jeremiah  |  |  | Middle<br>Hostetler   |  |  | Last<br>Hostetler   |  |  | 15. MOTHER'S MAIDEN NAME<br>Amanda   |  |  | First<br>Amanda   |  |  | Middle<br>Sanner |  |  | Last<br>Sanner |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>NO   |  |  | (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br>WILLIAM M. FLOWERS-334 N. MECHANIS ST.-CUMB.MD.                                |  |  | ADDRESS  |  |  |   |  |  |                  |  |  |                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u><br>(b) <u>Coronary Sclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>---</u>   |  |  |  |  |  |   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>24 Hours     |  |  |                  |  |  |                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>"Influenza"   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |  |  | 2D. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
| ACTUAL<br>SIGNATURE <u>Benedict Skitarelic</u>  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |  |  | 22b. DATE SIGNED<br>January 7, 1968  |  |  | ADDRESS (Street, city, town, or county)<br>Cumberland, Maryland |  |  |                  |  |  |                |  |  |
| EXAMINER'S<br>NAME (Type)<br>BENEDICT SKITARELIC, M.D.  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  |  | 23b. DATE<br>JANUARY 10, 1968  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HIGHLAND CEMETERY   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>GARRETT, SOMERSET, PENNSYLVANIA                |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |
| 24. FUNERAL DIRECTOR<br>JOHN J. HAFFER, JR. 230 BALTO. AVE. CUMBERLAND, MD.   |  |  | 25a. REC'D BY REGISTRAR<br>DATE JAN 10 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |   |  |  |  |  |  |   |  |  |                  |  |  |                |  |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |                              |   |  |   |  |  |                    |   |                                      |                        |  |
|--|--|---|------------------------------|---|--|---|--|--|--------------------|---|--------------------------------------|------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |                              |   |  |   |  |  |                    |   |                                      |                        |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |   | First Middle Last            |   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |  |  | 2b. HOUR           |   |                                      |                        |  |
| Henry Eckard Free  |  |   |                              |   |  | Month Day Year  |  |  | 1:00 P.M.          |   |                                      |                        |  |
| 3. SEX   |  | 4. RACE   |                              | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                    | IF UNDER 24 HRS<br>HOURS MIN.   |                                      |                        |  |
| Male   |  | White   |                              | Jan. 11, 1899   |  | 68 YRS.   |  |  |                    |   |                                      |                        |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  |   | 7b. CITIZEN OF WHAT COUNTRY? |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH |   |                                      |                        |  |
| Maryland   |  |   | USA                          |   |  |   |  |  | Allegany Md.       |   |                                      |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |                    |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |                        |  |
| Cumberland La Vale   |  |   |                              | National Highway  |  |   |  | Retired Clerk  |                    |   | Railroad                             |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  |   |                              | 13b. COUNTY   |  |   |  | 13c. CITY OR TOWN  |                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET AND NUMBER |  |
| Md.  |  |   |                              | Allegany  |  |   |  | Cumberland   |                    |   |                                      | 109 Grand Ave.         |  |
| 14. FATHER'S NAME  |  |   | First Middle Last            |   |  | 15. MOTHER'S MAIDEN NAME  |  |  | First Middle Last  |   |                                      |                        |  |
| Mark Eckard  |  |   | XENIXY Eckard Free           |   |  | Emily Kunes   |  |  |                    |   |                                      |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |   |                              | 16b. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT<br>ADDRESS   |                    |   |                                      |                        |  |
| no   |  |   |                              |   |  |   |  | Mrs. Anna F. Free, Cumberland, Md. Wife  |                    |   |                                      |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CORONARY OCCLUSION<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CORONARY SCLEROSIS<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |                              |   |  |   |  |  |                    | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>SUDDEN<br>---                                |                                      |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |  |   |                              |   |  |   |  |  |                    |   |                                      |                        |  |
| 19a. DATE OF OPERATION   |  |   |                              | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |  |   |  |  |                    | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                      |                        |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |   |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                       |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |                    |   |                                      |                        |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |                              |   |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |                    | County State  |                                      |                        |  |
| 22a. I certify that I took charge of the remains described above, held an <del>ANATOMICAL</del> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |   |                              |   |  |   |  |  |                    |   |                                      |                        |  |
| ACTUAL<br>SIGNATURE  |  | Benedict Skitarelic, M.D.   |                              |   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                    | 22b. DATE SIGNED  |                                      |                        |  |
| EXAMINER'S<br>NAME (Type)  |  | BENEDICT SKITARELIC, M.D.   |                              |   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                |                    | January 3, 1968   |                                      |                        |  |
| ADDRESS (Street, city, town, or county)  |  |   |                              |   |  |   |  |  |                    | Cumberland, Maryland  |                                      |                        |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |                              | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION (City or Town) (County) (State)  |                    |   |                                      |                        |  |
| Burial   |  | Jan. 6, 1968  |                              | Greenmount Cemetery   |  |   |  | Cumberland Allegany, Md.   |                    |   |                                      |                        |  |
| 24. FUNERAL DIRECTOR<br>James F. Scarpelli, Cumberland, Md.  |  |   |                              |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE JAN 8 1968   |                    | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                                      |                        |  |

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(255) 7349



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |                        |   |                      |  |   |   |                         |   |  |  |  |                     |  |
|---|--|--|--|--|------------------------|---|----------------------|--|---|---|-------------------------|---|--|--|--|---------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                        |   |                      |  |   |   |                         |   |  |  |  |                     |  |
| CERTIFICATE OF DEATH  |  |  |  |  |                        |   |                      |  |   |   |                         |   |  |  |  |                     |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>HARRY</b>   |  |  | First<br><b>W</b>  |  | Middle<br><b>FRITZ</b> |   | Last<br><b>FRITZ</b> |  | 2a. DATE OF DEATH<br>Month <b>JAN</b> Day <b>20</b> Year <b>68</b>                              |   | 2b. HOUR<br><b>7:45</b> |   |  |  |  |                     |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>WHITE</b>  |  |                        | 5. DATE OF BIRTH<br><b>8-13-98</b>  |                      |  | 6. AGE (In years last birthday)<br><b>69</b> YRS.   |   |                         | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> |  |                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>FRANKLIN CO., PA</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |                        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                      |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.   |   |                         |   |  |  |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |  |                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>SWIFT AND COMPANY</b>   |                      |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |                         |   |  |  |  |                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>ALLEGANY</b>   |  |                        | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                         | 13e. STREET AND NUMBER<br><b>RT. 2, BOX 222</b> |  |  |  |                     |  |
| 14. FATHER'S NAME<br><b>MERRITT</b>   |  |  | First<br><b>A.</b>   |  | Middle<br><b>FRITZ</b> |   | Last<br><b>FRITZ</b> |  | 15. MOTHER'S MAIDEN NAME<br><b>ADA</b>  |   |                         | First<br><b>M</b>                               |  | Middle<br><b>PHENICIE</b>                      |  | Last<br><b>ICIE</b> |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-05-6893</b>   |  |                        | 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>   |                      |  | Address<br><b>CUMBERLAND, MD.</b>   |   |                         |   |  |  |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Long Advanced Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |  |  |                        |   |                      |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>One wk</b> |                         |   |  |  |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4201</b>   |  |  |  |  |                        |   |                      |  |   |   |                         |   |  |  |  |                     |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |                         |   |  |  |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |                        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)   |                      |  |   |   |                         |   |  |  |  |                     |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |                        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                      |  |   |   |                         |   |  |  |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3-21-1967</b> to <b>1-20-1968</b> , that (I) (we) last saw the deceased alive on <b>1-20-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |                        |   |                      |  |   |   |                         |   |  |  |  |                     |  |
| 22b. SIGNATURE<br><b>Wm. F. Williams</b>  |  |  | 22c. DATE SIGNED<br><b>1-20-68</b>   |  |                        | 22d. PHYSICIAN'S NAME (Type)<br><b>DR. W. F. WILLIAMS</b>   |                      |  |   |   |                         |   |  |  |  |                     |  |
| 22e. ADDRESS<br><b>CUMBERLAND, MD.</b>  |  |  |  |  |                        |   |                      |  |   |   |                         |   |  |  |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE<br><b>22 JAN 68</b>  |  |                        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SUNSET MEMORIAL PARK</b>   |                      |  | 23d. LOCATION (City or Town) (County) (State)<br><b>RFD#3 CUMBERLAND ALLEG. MD</b>              |   |                         |   |  |  |  |                     |  |
| 24. FUNERAL DIRECTOR<br><b>H. LEE SILCOX</b>  |  |  | ADDRESS<br><b>404 DECATUR ST., CUMBERLAND MD</b>   |  |                        | 25a. REC'D BY REGISTRAR<br><b>JAN 24 1968</b>   |                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |                         |   |  |  |  |                     |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00031

|   |                         |   |  |  |   |  |   |  |  |
|---|-------------------------|---|--|--|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>LARRY DEAN GARLITZ</b>   |                         |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>JAN.</b> Day <b>29</b> Year <b>1968</b> |  |   | 2b. HOUR <b>8:50 PM</b>  |   |  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br><b>MARCH 1, 1951</b>  | 6. AGE (in years last birthday)<br><b>16</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  | 2c. DATE PRONOUNCED DEAD<br>Month <b>January</b> Day <b>20</b> Year <b>1968</b>              |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>ALLEGANY CO.</b>  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND (Rural)</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSP.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>STUDENT</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STUDENT</b>                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |                         | 13b. COUNTY <b>ALLEGANY</b>   |  | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>RFD #1 HOMEWOOD ADDITION</b>                      |  |
| 14. FATHER'S NAME<br><b>ELMER FRANCIS GARLITZ</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br><b>MARGARET D. GORDON</b>  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br><b>MR. ELMER GARLITZ RFD #1 HOMEWOOD ADDITION</b>   |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b><br><b>813.6</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Skull Fracture</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>(Struck by Automobile)</b>                           |                         |   |  |  |   |  |   | CUMBERLAND, MD. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 Hours</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>813.4</b>  |                         |   |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         | 21b. TIME OF INJURY Month, Day, Year<br><b>3:45 P.M. Jan. 20, 1968</b>                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Car struck bicycle</b>   |   |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Rt. # 36</b>       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>.2 miles north Rt. 40 Allegany, Md.</b>   |   |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |  |   |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Benedict Skitarelic</b>  |                         | M.D.<br><b>Benedict Skitarelic, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                               |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                               |  |
| EXAMINER'S NAME (Type)  |                         |   |  | ADDRESS (Street, city, town, or county)<br><b>Cumberland, Maryland</b>   |   | 22b. DATE SIGNED<br><b>January 20, 1968</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>24 JAN 68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>REST LAWN MEMORIAL PARK</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>CASH VALLEY RD. ALLEG. MD.</b>           |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>H. LEE SILCOX 404 DECATUR ST. CUMBERLAND, MD.</b>  |                         |   |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 24 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                               |  |

15900

1700

00503145

ST/IS-IT 1.042

5

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |   |  |  |
|--|--|--|--|--|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |   |  |  |
| 00032 CERTIFICATE OF DEATH 00032   |  |  |  |  |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle   | Last  | 2a. DATE OF DEATH   |   |  | 2b. HOUR   |
| SAMUEL   |  |  | E.   |  | GAUMER  | 1 Month 17 Day 68 Year  |   |  | 1:38 A M   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR  |  |
| MALE   |  | WHITE  |  | 04-21-89   |   | 78 YRS.   |   | MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |  |  |
| PENNSYLVANIA   |  | U.S.A.   |  |  |   | ALLEGANY COUNTY Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| CUMBERLAND   |  |  | SACRED HEART HOSPITAL  |  |   | BALTIMORE & OHIO R.R.   |   |  | RAILROAD   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| PENNSYLVANIA   |  |  |  | HYNDMAN  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   | 13e. STREET AND NUMBER   |  |
|  |  |  |  |  |   |   |   | RT. #1, HYNDMAN, PA. 15545   |  |
| 14. FATHER'S NAME  |  |  | First  | Middle   | Last  | 15. MOTHER'S MAIDEN NAME  |   |  | First Middle Last  |
| CHARLES  |  |  |  |  | GAUMER  | SHUMAKER  |   |  | ELIZABETH GAUMER   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT   |   |  | Address  |
| YES  |  |  | WW 1   |  |   | HOSPITAL RECORD'S   |   |  | 900 SETON DRIVE CUMB., MD. 21502   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br><u>4369</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>331X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>hours</u><br><u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Bronchopneumonia and Influenza</u>  |  |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
|  |  |  |  |  |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |  |  |
|  |  |  |  |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |   |  |  |
|  |  |  |  |  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>68</u> , to <u>1/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  | ATTENDING PHYS.   | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED   |  |
| <u>[Signature]</u>   |  |  |  |  |   |   |   | <u>1/18/68</u>   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS  |   |   |  |  |
| DR. J. A. PAGAN  |  |  |  |  | 5 POTOMAC STREET, RIDGELEY, W. VA. 26753  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |   |  |  |
| Burial   |  | Jan. 20, 1968  |  | Porter Cemetery  |   | Hyndman, Pa. RD#1   |   |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |   |  |  |
| ZIEGLER FUNERAL HOME - HYNDMAN, PENNSYLVANIA   |  | 15545  |  | JAN 22 1968  |   | <u>[Signature]</u>  |   |  |  |





FOR STATE  
HEALTH DEPT.

00033

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00033

|   |         |   |  |  |  |   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
|---|---------|---|--|--|--|---|--|---|--|---|--|--------------------------|--|------------------|--|----------|--|------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First   |  | Middle   |  | Last  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED                           |  | Month   |  | Day                      |  | Year             |  | 2b. HOUR |  |      |  |
| ROBERT  |         | T   |  | GREENE   |  |   |  | JAN. 31, 1968   |  | 10:45   |  | PM                       |  |                  |  |          |  |      |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS   |  | IF UNDER 24 HRS<br>HOURS  |  | MIN.  |  | 2c. DATE PRONOUNCED DEAD |  | Month            |  | Day      |  | Year |  |
| Male  | White   | 6-21-39   |  | 28   |  | YRS.  |  |   |  |   |  | January 31, 1968         |  | 10:45            |  | PM       |  |      |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED   |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH  |  |   |  |                          |  |                  |  |          |  |      |  |
| Maine   |         | USA   |  | WIDOWED  |  | DIVORCED  |  | Allegany  |  |   |  |                          |  |                  |  |          |  |      |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| Cumberland  |         | Memorial Hospital   |  | Laborer  |  | Orchard   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER  |  |   |  |                          |  |                  |  |          |  |      |  |
| W. Va.  |         |   |  | Paw Paw  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | Rt 1 Paw Paw, W. Va.  |  |   |  |                          |  |                  |  |          |  |      |  |
| 14. FATHER'S NAME   |         | First   |  | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME  |  | First   |  | Middle                   |  | Last             |  |          |  |      |  |
| Clyde Carlyle   |         | Greene  |  |  |  |   |  | Margaret  |  | Marguerite  |  | Manson                   |  |                  |  |          |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| Yes   |         | Not known   |  | 006-34-9359  |  | Memorial Hospital--Cumberland, Md.                                  |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |         | IMMEDIATE CAUSE (a)   |  | Pulmonary Embolism   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  | 36 Hrs.   |  |   |  |                          |  |                  |  |          |  |      |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.   |         | (b)   |  | Maceration of abdominal<br>tissue from gunshot wound.                                      |  | 3 1/2 Days  |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| (c)   |         |   |  |  |  |   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |   |  |  |  |   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |  | Gunshot of Abdomen   |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                          |  |                  |  |          |  |      |  |
| January 28, 1968  |         |   |  |  |  |   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING<br>CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |  |   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
|   |         | Jan. 28 1968  |  | Gunshot of Back  |  |   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE<br>AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County  |  | State   |  |                          |  |                  |  |          |  |      |  |
|   |         | Keifer, Maryland  |  | Keifer, Near Oldtown, Allegany, Md.  |  |   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: |         | Natural causes <input type="checkbox"/>   |  | Accident <input type="checkbox"/>  |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input checked="" type="checkbox"/>                        |  | Undetermined manner <input type="checkbox"/>                |  |                          |  |                  |  |          |  |      |  |
| ACTUAL<br>SIGNATURE   |         | Benedict Skitarelic   |  | M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                     |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                 |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED         |  | January 31, 1968 |  |          |  |      |  |
| EXAMINER'S<br>NAME (Type)   |         | BENEDICT SKITARELIC, M.D.   |  | ADDRESS (Street, city, town, or county)  |  | Cumberland, Maryland  |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)  |  | (County)  |  | (State)   |  |                          |  |                  |  |          |  |      |  |
| Burial  |         | 2/4/1968  |  | Camp Hill  |  | Paw Paw, (Morgan) W. Va.  |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| 24. FUNERAL DIRECTOR  |         | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |                          |  |                  |  |          |  |      |  |
| Johnson Funeral Home, Berkeley Springs, W. Va.  |         |   |  | FEB 5 1968   |  | Charles Judge   |  |   |  |   |  |                          |  |                  |  |          |  |      |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |   |  |                                   |  |                  |
|--|--|--|--|--|---|--|---|--|-----------------------------------|--|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |   |  |                                   |  |                  |
| 00034 CERTIFICATE OF DEATH 00034   |  |  |  |  |   |  |   |  |                                   |  |                  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR                          |  |                  |
| THOMAS   |  |  | H. GRIFFITHS   |  |   | JANUARY 6, 1968  |   |  | M                                 |  |                  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |  | 6. AGE (In years last birthday)                                     |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |
| MALE   |  | WHITE  |  | AUG. 1, 1883   |   |  | 84 YRS.   |  | MONTHS DAYS                       |  | HOURS MIN        |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. COUNTY OF DEATH  |  |                                   |  |                  |
| PENNSYLVANIA   |  | U.S.A.   |  |  |   |  | ALLEGANY Md.  |  |                                   |  |                  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |
| FROSTBURG  |  |  | MINERS HOSPITAL  |  |   | RETIRED MAINTENANCE  |   |  | BALLISTICS                        |  |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER            |  |                  |
| MD.  |  |  | ALLEGANY   |  | FROSTBURG   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 61 FROST AVENUE                   |  |                  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                                   |  |                  |
| First Middle Last  |  |  | First Middle Last  |  |   |  |   |  |                                   |  |                  |
| WILLIAM  |  |  | GRIFFITHS  |  |   | MARY PRICE   |   |  |                                   |  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT  |   |  | Address                           |  |                  |
| NO   |  |  | 232-09-8138  |  |   | MRS. EVAN LAYMAN, FROSTBURG, MD.   |   |  | 61 FROST AVENUE 21532             |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |   |  |                                   |  |                  |
| IMMEDIATE CAUSE (a) 486x ACUTE BILATERAL PNEUMONITIS   |  |  |  |  |   |  |   |  |                                   | 7 days                                       |                  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |   |  |                                   |  |                  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492x  |  |  |  |  |   |  |   |  |                                   |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |  |   |  |                                   |  |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |  |   |  |                                   |  |                  |
| CHRONIC OBSTRUCTIVE PULMONARY DISEASE  |  |  |  |  |   |  |   |  |                                   |  |                  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |   | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |                  |
|  |  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |   |  |                                   |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |  |                                   |  |                  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |   |  |   |  |                                   |  |                  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION   |  |   |  |                                   |  |                  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work  |  |  |  |  | Street or R.F.D. No. City or Town County State                                  |  |   |  |                                   |  |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from DEC. 31, 1967, to JAN. 6, 1968, that (I) (we) last saw the deceased alive on JAN. 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |   |  |                                   |  |                  |
| 22b. SIGNATURE   |  |  |  |  |   | DEGREE   |   |  | 22c. DATE SIGNED                  |  |                  |
| A. Paige Strong  |  |  |  |  |   |  |   |  | 1/6/68                            |  |                  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |   | 22e. ADDRESS   |   |  |                                   |  |                  |
| A. PAIGE STRONG, M. D.   |  |  |  |  |   | E. MAIN ST., FROSTBURG, MD.  |   |  |                                   |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |  | 23d. LOCATION (City or Town) (County) (State)                       |  |                                   |  |                  |
| BURIAL   |  | JAN. 9, 1968   |  | MT. ZION CEMETERY  |   |  | GARRETT COUNTY, MD.   |  |                                   |  |                  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |   | 25a. REC'D BY REGISTRAR  |   |  | 25b. REGISTRAR'S SIGNATURE        |  |                  |
| JOSEPH R. DURST, SR., FROSTBURG, MD. 21532   |  |  |  |  |   | JAN 11 1968  |   |  | Charles Judge                     |  |                  |

000001

000001

TRADING COMPANY LIMITED

INCORPORATED IN THE STRAITS SETTLEMENTS

REGISTERED OFFICE: 10, RAFFLES PLACE, SINGAPORE.

BRANCHES: KUALA LUMPUR, JOHORE BAHRU, PENANG, MALACCA.

TELEGRAMS: "TRADING" SINGAPORE.

TELEPHONE: 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110.

POSTAL ORDER: "TRADING" SINGAPORE.

CHEQUES: "TRADING" SINGAPORE.

DEBIT NOTES: "TRADING" SINGAPORE.

CREDIT NOTES: "TRADING" SINGAPORE.

RECEIPTS: "TRADING" SINGAPORE.

INVOICES: "TRADING" SINGAPORE.

STATEMENTS: "TRADING" SINGAPORE.

ACCOUNTS: "TRADING" SINGAPORE.

LEDGERS: "TRADING" SINGAPORE.

BOOKS: "TRADING" SINGAPORE.

PAPERS: "TRADING" SINGAPORE.

STATIONERY: "TRADING" SINGAPORE.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00035

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00035

|   |                         |   |  |  |  |  |   |   |  |
|---|-------------------------|---|--|--|--|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Wilbur David Grove</b>   |                         |   | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> <b>Jan 6</b> 19 <b>68</b> 3:00 PM |  |  | 2b. HOUR   |   |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Jan. 13, 1907</b>  | 6. AGE (In years last birthday)<br><b>60</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  | IF UNDER 24 HRS.<br>HOURS<br>MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Jan</b> Day <b>6</b> Year <b>1968</b> 3:15 PM           |   |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Allegany</b> Md.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Westernport</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br><b>420 Walnut</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Farmer</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm</b>                                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                         | 13b. COUNTY <b>Allegany</b>   |  | 13c. CITY OR TOWN<br><b>Westernport</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>420 Walnut</b>                   |  |
| 14. FATHER'S NAME First <b>James</b> Middle <b>L</b> Last <b>Grove</b>  |                         |   | 15. MOTHER'S MAIDEN NAME First <b>Harriett</b> Middle <b>L. Fazenbaker</b> Last                          |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>216-07-8119</b>  |  | 17. INFORMANT ADDRESS<br><b>Anderson Grove-Westernport, Md.</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410.9</b> <b>Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Coronary Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b>  |                         |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |                         |   |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                      |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |   | County State  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |  |  |  |   |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>   |                         |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | 22b. DATE SIGNED <b>January 6, 1968</b>  |   |   |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>   |                         |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |   |   |  |
| ADDRESS (Street, city, town, or county) <b>Cumberland, Md.</b>  |                         |   |  |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>1/9/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Philos</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Westernport Md.</b>                      |   |   |  |
| 24. FUNERAL DIRECTOR <b>F. J. Bral</b> ADDRESS <b>Westernport, Md.</b>  |                         |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |   |   |  |

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FOR STATE  
RECORD DEPT

DATE OF BIRTH

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11-11-11

CH

*Benjamin B. B. B.*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00036

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00036

|  |  |  |  |   |   |  |   |  |   |                                |  |
|--|--|--|--|---|---|--|---|--|---|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)<br>Leota   |  |  | First<br>R.  | Middle<br>Gurley  | Lost  | 2a. DATE OF DEATH<br>Month Day Year<br>Jan. 24 1968                      |   |  | 2b. HOUR<br>7 P M                           |                                |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>Apr. 25, 1889   |   | 6. AGE (In years<br>lost birthday)<br>78 YRS.                            |   | IF UNDER 1 YEAR<br>MONTHS DAYS                   |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Allegany Md.                                       |   |  |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br>LaVale  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>27 Parkside Blvd. |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Own Home |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Allegany  |   | 13c. CITY OR TOWN<br>LaVale   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>27 Parkside Blvd. |                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Charles R. Eyler   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Annie (Mugrove) Eyler |   |   |  |   |  |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) (If yes give war or dates of service)<br>No.   |  |  | 16b. SOCIAL SECURITY NO.<br>None                                       |   | 17. INFORMANT<br>Address<br>Mrs. Leo Ford 27 Parkside Blvd. LaVale, Md.                                 |  |   |  |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u><br>436.9 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. 331X (b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 days |  |  |  |   |   |  |   |  |   |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Art. C. V. D. - Diabetes Mellitus</u>   |  |  |  |   |   |  |   |  |   |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                         |  |   |  |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                      |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 57</u> , 19 <u>57</u> , to <u>Jan 24</u> , 19 <u>68</u> , that (I) ( <del>we</del> ) last<br>saw the deceased alive on <u>Jan 24</u> , 19 <u>68</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the<br>causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>view</del> ) view the body after death.   |  |  |  |   |   |  |   |  |   |                                |  |
| 22b. SIGNATURE<br><u>Thomas F. Lushy</u>   |  |  |  |   | DEGREE<br>ATTENDING<br>PHYS.  |  | MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><u>1/26/68</u>          |                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Dr. Thomas F. Lushy   |  |  |  |   | 22e. ADDRESS<br>932 National Highway LaVale, Md.  |  |   |  |   |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Jan. 27, 1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Cumberland Allegany Md. |   |  |   |                                |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Byron Knight Cumberland, Md.  |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 2 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |                                |  |

2300

742900

2005

tributary, reduced order

83/24/1

James C. Gandy

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100037

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00037

|  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|-------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>FRANCES</b>  |  |  | First<br><b>V.</b>  |  |  | Middle<br><b>HAINES</b>   |  |  | Last  |  |  | 2a. DATE OF DEATH<br><b>JANUARY</b> <sup>Month</sup> <b>18</b> <sup>Day</sup> <b>1968</b> <sup>Year</sup> |  |  | 2b. HOUR<br><b>10:50P</b>     |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br><b>JUNE 5, 1916</b>   |  |  | 6. AGE (In years last birthday)<br><b>51</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.   |  |  |   |  |  |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SACRED HEART HOSP.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  |  |   |  |  |                               |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>ALLEGANY</b>  |  |  | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>111 ARCH STREET</b>  |  |  |                               |  |  |
| 14. FATHER'S NAME<br><b>JAMES</b>  |  |  | First<br><b>GLOSSER</b>   |  |  | Middle<br><b>GERTRUDE</b>   |  |  | Last<br><b>STEWART</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>GERTRUDE STEWART</b>   |  |  |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |  |  | 17. INFORMANT<br><b>HOSPITAL RECORD</b><br>Address  |  |  |   |  |  |   |  |  |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>stroke</u><br><b>432.9</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unbroken of both coronal arteries</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1-5-68</b><br><b>1-5-68</b> |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>334X</b>   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |   |  |  |                               |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                               |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-4-</u> , 19 <u>68</u> , to <u>1-18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
| 22b. SIGNATURE<br><i>L Brings</i>  |  |  | DEGREE  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>1-19-68</b>  |  |  |   |  |  |                               |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>LEWIS BRINGS, M.D.</b>  |  |  | 22e. ADDRESS<br><b>57 GREENE ST., CUMBERLAND, MD.</b>   |  |  |   |  |  |   |  |  |   |  |  |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Jan. 21, 1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Md.</b>                 |  |  |   |  |  |                               |  |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 23 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |   |  |  |                               |  |  |

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FRANCIS

WILKES

1 JULY 1 1951

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FEMALE

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JUNE 25 1910

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WYLAND

USA

WYLAND

CLEVELAND

WYLAND

WYLAND

WYLAND

WYLAND

111 1001 STREET

JAMES

CLOSER

WYLAND

HOSPITAL RECORD

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LEWIS BRIDGE, N.D.

27 GREENE ST., CLEVELAND, OH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |                           |                             |  |
|--|--|--|--|--|--|--|--|--|---------------------------|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |                           |                             |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |                           |                             |  |
| 1. DECEASED-NAME (Type or print) <b>Albert H. Hanekamp</b>   |  |  |  |  |  | 2a. DATE OF DEATH <b>1/18/1968</b>   |  |  | 2b. HOUR <b>7:30 A.M.</b> |                             |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH <b>1/3/1903</b>   |  | 6. AGE (In years last birthday) <b>65</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS                |                           | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Allegany</b> Md.   |  |  |                           |                             |  |
| 10. CITY OR TOWN OF DEATH <b>Lonaconing</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street and address) <b>Miners Hosp Railroad Street</b>                   |  | 12a. USUAL OCCUPATION (Kind of work done during preceding 10 years if not in hospital) <b>Retired Custodial School</b>                                   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                           |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  | 13b. COUNTY <b>Allegany</b>  |  | 13c. CITY OR TOWN <b>Lonaconing</b>  |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 13e. STREET AND NUMBER <b>Railroad St.</b> |                           |                             |  |
| 14. FATHER'S NAME First Middle Last <b>William H. Hanekamp</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Holder</b>   |  |  |  |  |                           |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)   |  | 17. INFORMANT <b>Blanch Hanekamp, Lonaconing, Md.</b> Address  |  |  |  |  |                           |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |                           |                             |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |                           |                             |  |
| IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> (WIFE)  |  |  |  |  |  |  |  |  |                           |                             |  |
| DUE TO, OR AS A CONSEQUENCE OF <b>AH CVD</b>   |  |  |  |  |  |  |  |  |                           |                             |  |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |                           |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |                           |                             |  |
| <b>443X</b>  |  |  |  |  |  |  |  |  |                           |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |                           |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |                           |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |                           |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/16</b> , 19 <b>68</b> , to <b>1/18</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |                           |                             |  |
| 22b. SIGNATURE <b>John B. Davis</b>  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <b>1/29/68</b>  |  |  |  |  |                           |                             |  |
| 22d. PHYSICIAN'S NAME (Type) <b>John B. Davis</b>  |  | 22e. ADDRESS <b>Frostburg, Md.</b>   |  |  |  |  |  |  |                           |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>1/20/1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>  |  | 23d. LOCATION (City or Town) <b>Lonaconing, Md.</b>  |  | (County) (State)                           |                           |                             |  |
| 24. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>  |  | ADDRESS <b>Lonaconing, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>JAN 23 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |                           |                             |  |

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UNITED STATES DEPARTMENT OF STATE  
WASHINGTON, D. C. 20520

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 1-68  
30M REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |   |   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
|---|--|--|---|--|--|---|--|---|---|---|--|--|--|--------------------------------|---|--|--|------------------------|--|--|----------------------|--|--|
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |   |   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><i>Mary</i>  |  |  | Middle<br><i>Elizabeth</i>  |  |   | Last<br><i>Hast</i>   |   |  | 2a. DATE OF DEATH<br><i>March</i> <i>Jan.</i> <i>4</i> , <i>1968</i> |  | 2b. HOUR<br><i>1:20 A</i>      |   |  |  |                        |  |  |                      |  |  |
| 3. SEX<br><i>Female</i>   |  |  | 4. RACE<br><i>White</i>   |  |  | 5. DATE OF BIRTH<br><i>Sept. 14, 1887</i>   |  |   | 6. AGE (In years last birthday)<br><i>80</i> YRS.                                 |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN. |   |  |  |                        |  |  |                      |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i> Md.</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i> U.S.A.</i>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br><i>Allegany</i> Md.   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Cumberland</i>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Sacred Heart Hosp.</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>                              |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i> Md.</i>  |  |  | 13b. COUNTY<br><i>Allegany</i>  |  |  | 13c. CITY OR TOWN<br><i>LaVale</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>720 Braddock St.</i> |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 14. FATHER'S NAME<br><i>Franklin</i>  |  |  | First<br><i>Franklin</i>  |  |  | Middle<br><i>Haller</i>   |  |   | Last<br><i>Haller</i>   |   |  | 15. MOTHER'S MAIDEN NAME<br><i>Barah</i>                             |  |                                | First<br><i>Barah</i>                       |  |  | Middle<br><i>Potts</i> |  |  | Last<br><i>Potts</i> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <i>NO</i> , or (unknown)   |  |  | (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><i>None</i>   |  |   | 17. INFORMANT<br><i>Mr. Lewis F. Hast</i>   |   |  |  |  |                                | Address<br><i>213 Carroll St. Cumb. Md.</i> |  |  |                        |  |  |                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4129 Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 yrs.</i>        |  |                                |   |  |  |                        |  |  |                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4206</i>   |  |  |   |  |  |   |  |   |   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                |   |  |  |                        |  |  |                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/1</i> , 19 <i>68</i> , to <i>1/4</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1/3</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |   |  |  |   |  |   |   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 22b. SIGNATURE<br><i>J.A. Pagan</i>   |  |  | DEGREE<br><i>M.D.</i>   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |   | 22c. DATE SIGNED<br><i>1/5/68</i>   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>J.A. Pagan, M.D.</i>   |  |  | 22e. ADDRESS<br><i>5 Potomac St. Ridgeley, W. Va.</i>   |  |  |   |  |   |   |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>1/6/68</i>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Luke's Cemetery</i>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Cumberland, Allegany, Md.</i> |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |
| 24. FUNERAL DIRECTOR<br><i>H. Wayne George</i>  |  |  | ADDRESS<br><i>Cumberland, Md.</i>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>JAN 8 1968</i>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i>                             |   |  |  |  |                                |   |  |  |                        |  |  |                      |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |        |   |                                     |   |                 |  |  |   |  |                                       |  |
|---|--|---|--------|---|-------------------------------------|---|-----------------|--|--|---|--|---------------------------------------|--|
| 00040   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |        |   |                                     | 00040   |                 |  |  |   |  |                                       |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First   | Middle | Last  | 2a. DATE OF DEATH<br>Month Day Year |   | 2b. HOUR<br>A M |  |  |   |  |                                       |  |
| EMMIT   |  | C.  |        | HENRY   | JANUARY 27, 1968                    |   | 6:42            |  |  |   |  |                                       |  |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |                                     | 6. AGE (In years last birthday)   |                 | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |                                       |  |
| MALE  |  | WHITE   |        | 8/13/1889   |                                     | 78 YRS.   |                 |  |  |   |  |                                       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH  |                 |  |  |   |  |                                       |  |
| BERKLEY SP. W. VA.  |  | U.S.A.  |        |   |                                     | ALLEGANY  |                 | Md.  |  |   |  |                                       |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY   |                 |  |  |   |  |                                       |  |
| CUMBERLAND, MD.   |  | MEMORIAL HOSPITAL   |        | MAINTENANCE   |                                     | RAYON IND.  |                 |  |  |   |  |                                       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | 13e. STREET AND NUMBER   |  |   |  |                                       |  |
| MARYLAND  |  | ALLEGANY  |        | OLDTOWN   |                                     |   |                 | RT. 1  |  |   |  |                                       |  |
| 14. FATHER'S NAME<br>First Middle Last  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last   |        |   |                                     |   |                 |  |  |   |  |                                       |  |
| ALBERT HENRY  |  | SAVANNAH PENNEL   |        |   |                                     |   |                 |  |  |   |  |                                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT Address   |                                     |   |                 |  |  |   |  |                                       |  |
| NO  |  | 218 24 8594   |        | MEMORIAL HOSPITAL, CUMBERLAND, MD.  |                                     |   |                 |  |  |   |  |                                       |  |
| MEDICAL CERTIFICATION   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>A.S. Cardiovascular disease with terminal failure</u> 48 hours<br>185X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>177X</u><br>(b) <u>Pneumonia, long time, that bronchial</u> 4 days.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Encephalomyelitis with secondary neuron tract infection</u> 3 months |        |   |                                     |   |                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                                       |  |
|   |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Impending gangrene of foot &amp; leg. Rt. femoral aneurysm 18 in. Anterior mediastinal mass 2 years</u>   |        |   |                                     |   |                 |  |  |   |  |                                       |  |
|   |  | 19a. DATE OF OPERATION  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20a. AUTOPSY?   |                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |                                       |  |
|   |  | 18 Jan. 68  |        | Impending gangrene of foot & leg  |                                     | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |                 |  |  |   |  |                                       |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)   |                                     |   |                 |  |  |   |  |                                       |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                     |   |                 |  |  |   |  |                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>15 Dec., 1968</u> to <u>27 Dec., 1968</u> , that (I) (we) last saw the deceased alive on <u>26 Jan. 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |        |   |                                     |   |                 |  |  | 22b. SIGNATURE<br><u>W. Alfred Van Ormer</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>27 Jan. 68</u> |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | DR. WALTER N. HIMMLER   |        | 22e. ADDRESS<br><u>412 MECHANIC STREET, CUMBERLAND, MD.</u>   |                                     |   |                 |  |  |   |  |                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)   |                 |  |  |   |  |                                       |  |
| BURIAL  |  | JAN. 30, 1968   |        | SUNSET MEMORIAL PARK  |                                     | CUMBERLAND, MD.   |                 |  |  |   |  |                                       |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS   |  | BYRON KIGHT CUMBERLAND, MD.   |        | 25a. REC'D BY REGISTRAR<br>DATE   |                                     | FEB 2 1968  |                 | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                     |  |   |  |                                       |  |

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DR. WALTER N. HILGERS

NAME: \_\_\_\_\_

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 00041  |  |   |  |   |  |  |  |   |  |   |  |  |
|--|--|---|--|---|--|--|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |   |  |   |  |  |
| Item 13c Film G397 2/19/68 kk  |  |   |  |   |  |  |  |   |  |   |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |   |  |  |
| 00041  |  |   |  |   |  |  |  |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>FREDERICK</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>8</b> Year <b>1968</b>  |  |   | 2b. HOUR<br><b>12:35AM</b>   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>                       |  | 5. DATE OF BIRTH<br><b>1-20-84</b>  |  | 6. AGE (In years last birthday)<br><b>83</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>03</b> DAYS <b>03</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>03</b> MIN <b>00</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.  |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SACRED HEART HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>WOOD-WORKER</b>                          |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>LUMBER CO.</b>                               |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>ALLEGANY</b>   |   |  | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>262 NTL. HWY.</b>    |  |  |
| 14. FATHER'S NAME<br>First <b>JOHN</b> Middle <b>HERATH</b> Last <b>ELIZABETH</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ELIZABETH</b> Middle <b>PAUL</b> Last <b>PAUL</b>  |  |  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-05-6861</b>   |   |  | 17. INFORMANT<br>Address <b>HOSPITAL RECORD</b>  |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septic shock</b><br>5609 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5705</b><br>(b) <b>Partial intestinal obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Bed quiling for long time</b> |  |   |  |   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)<br><b>Rheumatoid Arthritis</b>  |  |   |  |   |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>12-7-68</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Urinary retention</b>                                 |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-21</b> , 19 <b>67</b> , to <b>1-8</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>1-7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Joel</b>  |  |   |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-9-68</b>   |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. JOSE VALDES</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>ALGONQUIN HOTEL, CUMBERLAND, MD.</b>  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>1/10/68</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Maryland</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>H. Lee Silcox</b>   |  |   |  |   |  | ADDRESS<br><b>SILCOX FUNERAL HOME, 404 DECATUR ST., CUMB.</b>  |  |   | 25a. REC'D BY REGISTRAR<br><b>MDIAN 11 1968</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>MDIAN 11 1968</b> |  |

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JANUARY 8, 1968 12:32

HERTH

HE

FREDERICK

NOTE

WHITE

1-20-68

X

COURTNEY, ID.

U.S.A.

ALL ID.

COURTNEY ID

SHARED REPT HOSPITAL

1000-MORRIS

THURSDAY, CO.

COURTNEY

ALL ID.

X

232 NTL. ID.

JOHN

HERTH

ELIZABETH

PAUL

NO

24-02-68 HOSPITAL RECORD

DR. JOSE L. LOES

LOOKING FOR HOTEL, COURTNEY, ID.

2 COX FULL, L. HOPE, 401 DECATUR ST., COURTNEY, ID.



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00042

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00042

|   |                         |   |  |   |                               |   |  |  |
|---|-------------------------|---|--|---|-------------------------------|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <i>Oliver Wendell Holmes</i>  |                         |   | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year <i>JAN. 29, 1968</i> |   |                               | 2b. HAM <i>4:50</i>   |  |  |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br><i>June 22, 1885</i>  | 6. AGE (In years last birthday)<br><i>82</i> YRS.                                      | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br><i>JANUARY 29, 1968</i>   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Penna.</i>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               | 9. COUNTY OF DEATH<br><i>Allegany</i>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Cumberland,</i>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Memorial Hosp.</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Laborer</i>   |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Gardening</i>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>   |                         | 13b. COUNTY<br><i>Allegany</i>  |  | 13c. CITY OR TOWN<br><i>Cumberland,</i>   |                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>115 Spruce St.</i>    |
| 14. FATHER'S NAME<br>First <i>Josiah</i> Middle <i>Holmes</i> Last <i>Holmes</i>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>First <i>Sarah</i> Middle <i>A.</i> Last <i>Wilton</i>     |   |                               |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>No.</i>  |                         | 16b. SOCIAL SECURITY NO.<br><i>220-07-6885</i>  |  | 17. INFORMANT<br><i>Mrs. Marshall H. Tewell</i>   |                               | ADDRESS<br><i>Wms. Rd. Cumb. Md.</i>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4129</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4221</i><br>(b) <i>CHRONIC MYOCARDITIS</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>MONTHS</i> |                         |   |  |   |                               |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>(FROSTBITE OF HANDS AND FEET)</i>  |                         |   |  |   |                               |   |  |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |   |                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <i>19</i>                                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                               |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                               |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>                         |                         |   |  |   |                               |   |  |  |
| ACTUAL SIGNATURE<br><i>Benedict Skitarelic</i>  |                         | M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                               | 22b. DATE SIGNED  |  |  |
| EXAMINER'S NAME (Type)<br><b>BENEDICT SKITARELIC, M.D.</b>  |                         |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                               | <b>JANUARY 29, 1968</b>   |  |  |
|   |                         |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                               | <b>CUMBERLAND, MARYLAND</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                         | 23b. DATE<br><i>1/31/68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Rose Hill Cemetery</i>   |                               | 23d. LOCATION (City or Town) (County) (State)<br><i>Cumberland, Allegany Md.</i>                |  |  |
| 24. FUNERAL DIRECTOR<br><i>H. Wayne George</i>  |                         |   |  | ADDRESS<br><i>Cumberland, Md.</i>   |                               | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 1 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i> |

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100 24717

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BENEDICT SKLARZ, M.D.

JANUARY 24, 1968  
COURT REPORT, HARTFORD

(FROSTBITE OF HANDS AND FEET)

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

CHRONIC RYODARDITIS

MONTHS

X

JANUARY 24, 1968  
COURT REPORT, HARTFORD

FOR STATE  
HEALTH DEPT.

00043

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00043

|  |         |                              |  |   |      |   |   |   |  |  |          |
|--|---------|------------------------------|--|---|------|---|---|---|--|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |   |      | 2a. DATE KNOWN OF DEATH   |   |   | 2b. HOUR   |  |          |
| Patrick J. Hopkins   |         |                              |  |   |      | Month Day Year  |   |   | 1:10 PM  |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR   |      | IF UNDER 24 HRS.  |   | 2c. DATE PRONOUNCED DEAD  |  |  | 2d. HOUR |
| Male   | White   | March 27, 1900               | 67 YRS.  | MONTHS  | DAYS | HOURS   | MIN.  | Month Day Year  |  |  | 1:10 PM  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |      | 9. COUNTY OF DEATH  |   |   |  |  |          |
| Maryland   |         | USA                          |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |      | Allegany  |   | Md.   |  |  |          |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |
| Cumberland   |         |                              | Sacred Heart   |   |      | Retired Storekeeper   |   |   | Railroad   |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |   |      | 13c. CITY OR TOWN   |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |
| Maryland   |         |                              | Allegany   |   |      | Cumberland  |   |   | 562 Fayette St.  |  |          |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |   |      |   |   |   |  |  |          |
| First Middle Last  |         |                              | First Middle Last  |   |      |   |   |   |  |  |          |
| Patrick H. Hopkins   |         |                              | Mary Wempe   |   |      |   |   |   |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |   |      | 17. INFORMANT   |   |   | ADDRESS  |  |          |
| no   |         |                              |  |   |      | Mrs. Helen Hopkins, Cumberland, Md.-Wife  |   |   |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |   |      |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| PART 1. DEATH WAS CAUSED BY:   |         |                              |  |   |      |   |   |   |  | Hours  |          |
| IMMEDIATE CAUSE (a) Irreversible Shock   |         |                              |  |   |      |   |   |   |  |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |   |      |   |   |   |  |  |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 441.2   |         |                              |  |   |      |   |   |   |  | 11   |          |
| (b) Hemorrhage   |         |                              |  |   |      |   |   |   |  |  |          |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |   |      |   |   |   |  |  |          |
| (c) Rupture Abdominal Aortic Aneurysm  |         |                              |  |   |      |   |   |   |  | 11   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |   |      |   |   |   |  |  |          |
| 451x   |         |                              |  |   |      |   |   |   |  |  |          |
| 19a. DATE OF OPERATION   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                     |      |   |   | 20. AUTOPSY?  |  |  |          |
|  |         |                              |  |   |      |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>  |         |                              | 21b. TIME OF INJURY Month, Day, Year   |   |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |   |   |  |  |          |
| CAUSE OF DEATH   |         |                              | HOUR A.M. P.M.   |   |      | 19  |   |   |  |  |          |
| 21d. INJURY OCCURRED   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |      | 21f. LOCATION Street or R.F.D. No.  |   |   | City or Town County State  |  |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                              |  |   |      |   |   |   |  |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |   |      |   |   |   |  |  |          |
| ACTUAL SIGNATURE   |         |                              | Benedict Skitarelic  |   |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   | 22b. DATE SIGNED   |  |          |
| EXAMINER'S NAME (Type)   |         |                              | BENEDICT SKITARELIC, M.D.  |   |      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                     |   |   | January 24, 1968   |  |          |
|  |         |                              |  |   |      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                             |   |   | ADDRESS (Street, city, town, or county) Cumberland, Maryland                                 |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE                    |  | 23c. NAME OF CEMETERY OR CREMATORY  |      |   | 23d. LOCATION (City or Town) (County) (State) |   |  |  |          |
| Burial   |         | Jan. 27, 1968                |  | St. Mary's Cemetery   |      |   | Cumberland Allegany Md.                       |   |  |  |          |
| 24. FUNERAL DIRECTOR   |         |                              |  |   |      | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |  |          |
| James F. Scarpelli, Cumberland, Md.  |         |                              |  |   |      | DATE JAN 29 1968  |   | Charles Judge   |  |  |          |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1/68

MEDICAL CERTIFICATION

00044

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00044

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |         |  |        |   |   |   |                 |                                   |                          |  |
|---|---------|--|--------|---|---|---|-----------------|-----------------------------------|--------------------------|--|
| 1. DECEASED NAME<br>(Type or Print)   |         | First  | Middle | Lost  | 2a. DATE KNOWN OF DEATH   |   | Month           | Day                               | Year                     | 2b. HOUR                                     |
| James Robert Houdershell  |         |  |        |   | OF ESTI- MATED  |   |                 | 1-8-68                            | 3:28A                    | M  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR   |   | IF UNDER 24 HRS |                                   | 2c. DATE PRONOUNCED DEAD |  |
| Male  | White   | March 28, 1915   |        | 52 YRS  | MONTHS  | DAYS  | HOURS           | MIN.                              | 2d. HOUR                 |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |                 |                                   |                          |  |
| Maryland  |         | USA  |        | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |   | Allegany Md   |                 |                                   |                          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |                 | 12b. KIND OF BUSINESS OR INDUSTRY |                          |  |
| Cumberland  |         | Memorial Hospital  |        |   |   |   |                 | Textile                           |                          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |                 | 13e. STREET AND NUMBER            |                          |  |
| W. Va.  |         | Mineral  |        | Wiley Ford  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                 | none                              |                          |  |
| 14. FATHER'S NAME   |         | First  | Middle | Lost  | 15. MOTHER'S MAIDEN NAME  |   | First           | Middle                            | Lost                     |  |
| Morton L. Houdershell   |         |  |        |   | Catherine Cook  |   |                 |                                   |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT   |   | ADDRESS   |                 |                                   |                          |  |
| no  |         |  |        | Miss Patricia Houdershell, Cumberland, Md.  |   | Daughter  |                 |                                   |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431.0 Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Rupture Left Cerebral Artery (c) Arteriosclerosis, Hypertension ----   |         |  |        |   |   |   |                 |                                   |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|   |         |  |        |   |   |   |                 |                                   |                          | Hours  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331x  |         |  |        |   |   |   |                 |                                   |                          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |        |   |   | 20. AUTOPSY?  |                 |                                   |                          |  |
|   |         |  |        |   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                 |                                   |                          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.                          |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)       |   |   |                 |                                   |                          |  |
|   |         | 19   |        |   |   |   |                 |                                   |                          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State                          |   |   |                 |                                   |                          |  |
|   |         |  |        |   |   |   |                 |                                   |                          |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> |         |  |        |   |   |   |                 |                                   |                          |  |
| ACTUAL SIGNATURE  |         | Benedict Skitarelic, M.D.  |        |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                     |                 | 22b. DATE SIGNED                  |                          |  |
| EXAMINER'S NAME (Type)  |         | BENEDICT SKITARELIC, M.D.  |        |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>         |                 | January 8, 1968                   |                          |  |
|   |         |  |        |   |   | ADDRESS (Street, city, town, or county)                             |                 | Cumberland, Md.                   |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                       |                 |                                   |                          |  |
| Burial  |         | Jan. 10, 1968  |        | Twigg Cemetery  |   | Near Oldtown Allegany Md.   |                 |                                   |                          |  |
| 24. FUNERAL DIRECTOR  |         | ADDRESS  |        |   |   | 25a. REC'D BY REGISTRAR   |                 | 25b. REGISTRAR'S SIGNATURE        |                          |  |
| James F. Scarpelli, Cumberland, Md.   |         |  |        |   |   | JAN 10 1968   |                 | Charles Judge                     |                          |  |

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January 1, 1950 3:50A

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00045

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00045

|   |  |   |  |   |  |   |  |  |  |                               |  |
|---|--|---|--|---|--|---|--|--|--|-------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br>May Blanche Hoyle   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>Jan. 9 1968             |   |  | 2b. HOUR<br>9:20 A M  |  |  |  |                               |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>May 6, 1893   |  | 6. AGE (In years last birthday)<br>74 YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS   |  | 8. UNDER 24 HRS.<br>HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Flintstone, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Allegany Md.  |  |  |  |                               |  |
| 10. CITY OR TOWN OF DEATH<br>Cumberland   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>D.O.A. Memorial |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                            |  |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Allegany   |  | 13c. CITY OR TOWN<br>Cumberland   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>217 Grand Avenue                               |  |                               |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Franklin Alderton   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Lavinia Kifer |   |  |   |  |  |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no   |  |   | 16b. SOCIAL SECURITY NO.                                       |   | 17. INFORMANT<br>Address<br>Mr. Raymond F. Hoyle, Edison, N.J. - Son                                 |   |  |  |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden Cardiac Failure</u><br>401X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis</u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 min<br>2 yrs<br>5 yrs |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)<br>444X   |  |   |  |   |  |   |  |  |  |                               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |                               |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE DE DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |                               |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, DECEASE BUILDING, ETC.)                   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |  |  |                               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1962</u> to <u>Jan 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |                               |  |
| 22b. SIGNATURE<br><u>Clay E. Durrett</u>  |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>Jan. 9, 1968  |  |  |  |                               |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Clay E. Durrett, M.D.   |  |   |  | 22e. ADDRESS<br>236 Virginia Ave., Cumberland, Md.  |  |   |  |  |  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Jan. 12, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Davis Memorial Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Cumberland, Md. Allegany                       |  |  |  |                               |  |
| 24. FUNERAL DIRECTOR<br>James F. Scarpelli, Cumberland, Md.   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE JAN 15 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |   |   |   |  |   |                   |
|--|--|--|--------------------------|---|---|---|--|---|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |   |   |   |  |   |                   |
| CERTIFICATE OF DEATH   |  |  |                          |   |   |   |  |   |                   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First                    | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year                                 |  |   | 2b. HOUR          |
| Myrtle Blanche Huffman   |  |  |                          |   |   | January 28, 1968  |  |   | 2:05 AM           |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)                                     |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                  |                   |
| Female   |  | White  |                          | July 2, 1892  |   | 75 YRS.   |  |   |                   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |   |                   |
| Hyndman, Pa.   |  | USA  |                          |   |   | Allegany Md.  |  |   |                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |                   |
| Cumberland   |  | 606 Maryland Avenue  |                          | Practical Nrs. Nursing  |   |   |  |   |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER  |                   |
| Pennsylvania   |  | Bedford  |                          | Hyndman   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |                   |
| 14. FATHER'S NAME  |  |  | First                    | Middle  | Last  | 15. MOTHER'S MAIDEN NAME  |  |   | First Middle Last |
| Christopher Ranker   |  |  |                          |   |   | Druzella Clites   |  |   |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT   |   |  |   | Address           |
| NO   |  |  | 171-16-9005              |   | Mrs. Mildred Glessner, Stoystown Pa.  |   |  |   | RD#1              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>428x</u> <u>Maemia</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 mon.</u> |  |  |                          |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u><br><u>5 yrs</u> |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4221</u>   |  |  |                          |   |   |   |  |   |                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                   |
|  |  |  |                          |   | YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1968</u> , to <u>Jan 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                          |   |   |   |  |   |                   |
| 22b. SIGNATURE <u>Clay Durrett</u> DEGREE  |  |  |                          |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>1/27/68</u>                                      |   |                   |
| 22d. PHYSICIAN'S NAME (Type) <u>Clay Durrett</u>   |  |  |                          |   | 22e. ADDRESS  |   |  |   |                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)                       |  |   |                   |
| Burial   |  | Jan. 31, 1968  |                          | Hyndman Cemetery  |   | Hyndman, Bedford Co., Pa.   |  |   |                   |
| 24. FUNERAL DIRECTOR   |  |  |                          |   | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |   |                   |
| Harvey H. Zeigler, Hyndman, Pa.  |  |  |                          |   | DATE FEB 5 1968   |   | <u>Charles Judge</u>   |   |                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00047

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00047

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Sarah Ellen Hunter</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>January</b> Day <b>27</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>6:30 PM</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>June 17, 1892</b>  |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Doddrudge Co.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Allegany</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Frostburg</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Miners Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Allegany</b>   |  | 13c. CITY OR TOWN<br><b>Frostburg</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>             |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>N.A.</b>                            |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>N.A.</b>   |  | 17. INFORMANT<br><b>Mr. Edward L. Hunter</b>   |  |   |  | Address <b>226 E. Main St., Frostburg, Md.</b>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4107</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>3 days</b>                        |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 6, 1968</b> , to <b>Jan. 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>Jan. 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>G. Paige Strong</b>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>Jan. 27, 1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>A. Paige Strong, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>East Main St., Frostburg, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 30, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Mem. Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Frostburg, Maryland</b>          |  |
| 24. FUNERAL DIRECTOR<br><b>Marlow M. Sowers</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  |
| ADDRESS<br><b>Marlow M. Sowers Home, 60 W. Main, Frostburg</b>  |  |  |  | DATE<br><b>FEB 1 1968</b>   |  |  |  |

Acute Myocardial Infarction

Exhibit 5 - Acute Myocardial Infarction

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in 1912



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00048

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00048

|   |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
|---|---------|--|--|--|--|--|--|---|--|--|--|--|--|------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  |  | Middle   |  | Last   |  | 2a. DATE KNOWN OF DEATH   |  | ESTIMATED <input checked="" type="checkbox"/> Month Day Year                     |  | 2b. HOUR                                     |  |      |  |
| Carrie  |         | L.   |  |  |  | James  |  | JAN. 3  |  | 1968   |  | 5:05 PM                                      |  |      |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR                                     |  |      |  |
| Female  | White   | Nov. 26, 1918  |  | 49 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.  |  | January Day 3  |  | 1968 5:00 PM                                 |  |      |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  |  |  |  |  |      |  |
| W. Va.  |         | USA  |  |  |  | Allegany   |  |   |  |  |  |  |  |      |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |  |  |      |  |
| Cumberland  |         | Memorial Hospital  |  | Housewife  |  | Own Home   |  |   |  |  |  |  |  |      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |  |  |  |  |      |  |
| W. Va.  |         | Mineral  |  | Wiley Ford   |  |  |  | Maple Street  |  |  |  |  |  |      |  |
| 14. FATHER'S NAME   |         | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME  |  | First  |  | Middle                                       |  | Last |  |
| Morton  |         | L.   |  | Houdershell  |  |  |  | Catherine   |  |  |  | Cook   |  |      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |  |  |      |  |
| no  |         |  |  |  |  | Mr. Ray O. James, Wiley Ford, W. Va.   |  | Husband   |  |  |  |  |  |      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |      |  |
| PART 1. DEATH WAS CAUSED BY:  |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| IMMEDIATE CAUSE (a) Cerebral Hemorrhage   |         |  |  |  |  |  |  |   |  |  |  | 5 Hours                                      |  |      |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| (b) Hypertensive cardiovascular disease   |         |  |  |  |  |  |  |   |  |  |  | Years  |  |      |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| (c)   |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| 443X  |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| 19a. DATE OF OPERATION  |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |      |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  |  | 21b. TIME OF INJURY Month, Day, Year   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |  |  |      |  |
|   |         |  |  | HOUR A.M. P.M. 19  |  |  |  |   |  |  |  |  |  |      |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |  |  |  |  |      |  |
|   |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |  |  |  |  |   |  |  |  |  |  |      |  |
| ACTUAL SIGNATURE  |         |  |  | Benedict Skitarelic, M.D.  |  |  |  |   |  | 22b. DATE SIGNED   |  |  |  |      |  |
| EXAMINER'S NAME (Type)  |         |  |  | Benedict Skitarelic, M.D.  |  |  |  |   |  | January 3, 1968  |  |  |  |      |  |
|   |         |  |  | ADDRESS (Street, city, town, or county)  |  |  |  |   |  | Cumberland, Md.  |  |  |  |      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   |  | 23d. LOCATION (City or Town) (County) (State)                                    |  |  |  |      |  |
| Burial  |         |  |  | Jan. 6, 1968   |  | Abe Cemetery   |  |   |  | Near Wiley Ford, W. Va. Mineral  |  |  |  |      |  |
| 24. FUNERAL DIRECTOR  |         |  |  |  |  | ADDRESS  |  |   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                   |  |      |  |
| James F. Scarpelli, Cumberland, Md.   |         |  |  |  |  |  |  |   |  | DATE JAN 8 1968  |  | J. Charles Judge                             |  |      |  |

2100

4206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |   |   |  |  |  |
|---|--|--|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |   |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>BESSIE CLARABEL KASECAMP</b>   |  |  |   |   | 2a. DATE OF DEATH<br>Month <b>1</b> Day <b>29</b> Year <b>68</b>  |   |  | 2b. HOUR P<br><b>9:05 M</b>                                      |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br><b>11-04-83</b>   |   | 6. AGE (In years last birthday)<br><b>84</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>ALLEGANY COUNTY</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SACRED HEART HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>                               |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>ALLEGANY</b>   |   | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>313 5TH STREET</b>                  |  |
| 14. FATHER'S NAME<br>First <b>DANIEL</b> Middle <b>S.</b> Last <b>RYAN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ROBERTSON</b> Middle <b>SARAH</b> Last <b>J. Robertson</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br><b>HOSPITAL RECORD</b>   |   | Address <b>900 SETON DRIVE CUMB., MD. 21502</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>7230 AZOTEMIA; GENERALIZED ARTERIOSCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ELECTROLYTE IMBALANCE; DEHYDRATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>OSTEOPOROSIS; COMPRESSION FRACT. VERTEBRA-OLD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2WKS</b><br><b>1 MONTH.</b> |  |  |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>733X DYSPHAGIA; CORONARY ARTERY DISEASE</b>  |  |  |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-24-1968</b> , to <b>1-29-1968</b> , that (I) (we) lost saw the deceased alive on <b>1-29-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Richard Schindler</b>  |  |  |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/1/68</b>                                    |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. R. SCHINDLER</b>   |  |  |   |   | 22e. ADDRESS<br><b>69 GREENE ST., CUMB., MD. 21502</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/1/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Memorial Burial Park</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Allegany Md.</b>                |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H. Wayne George</b><br><b>GEORGE FUNERAL HOME - 202 GREENE ST., CUMB.</b>  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 2 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |

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RECORDS DEPARTMENT

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GERMAN FEDERAL ARCHIVE - 308 2000 12 11 1990

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00050

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00050

|  |         |  |  |   |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
|--|---------|--|--|---|--|---|--|---|--|---|--|--------------------|--|----------|--|----------|--|----------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  |  | Middle  |  | Last  |  | 2a. DATE KNOWN OF DEATH                                     |  | Month                                   |  | Day                |  | Year     |  | 2b. HOUR |  |          |  |
| ELLA   |         | V.   |  | KERNS   |  |   |  | Jan. 16   |  | 19                                      |  | 68                 |  | 6:30     |  | P        |  |          |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD                |  | Month              |  | Day      |  | Year     |  | 2d. HOUR |  |
| FEMALE   | WHITE   | OCT. 26, 1891  |  | 76  |  | MONTHS  |  | DAYS  |  | January 16,                             |  | 19                 |  | 68       |  | 6:30     |  | P        |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED   |  | DIVORCED                                |  | 9. COUNTY OF DEATH |  |          |  |          |  |          |  |
| W. VA.   |         | USA  |  |   |  |   |  |   |  |   |  | ALLEGANY           |  |          |  |          |  | Md.      |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| CUMBERLAND   |         | MEMORIAL HOSPITAL  |  | Clerk   |  | Retail Dept.  |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                                      |  |   |  |                    |  |          |  |          |  |          |  |
| MD.  |         | ALLEGANY   |  | CUMBERLAND  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 35 FIFTH STREET   |  |   |  |                    |  |          |  |          |  |          |  |
| 14. FATHER'S NAME  |         | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME                                    |  | First                                   |  | Middle             |  | Last     |  |          |  |          |  |
| JOHN   |         |  |  |   |  | KERNS   |  | MARY  |  |   |  | ANN                |  | REYNOLDS |  |          |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| no   |         |  |  | Mr. Earl Manges, Cumberland, Md.  |  | -Attorney   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |         | PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | Pneumonia, Bilateral  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  | days                                    |  |                    |  |          |  |          |  |          |  |
| 486X   |         |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |         | 490X   |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  |   |  |   |  |                    |  |          |  |          |  |          |  |
|  |         |  |  | (c)   |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         | Malnutrition, Arteriosclerotic Cardiovascular Disease                        |  |   |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
|  |         | HOUR A.M. P.M. 19  |  |   |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |  | State                                   |  |                    |  |          |  |          |  |          |  |
|  |         |  |  |   |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | 22b. DATE SIGNED   |  | January 16, 1968  |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| ACTUAL SIGNATURE   |         | Benedict Skitarelic  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                 |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | ADDRESS (Street, city, town, or county) |  | Cumberland, Md.    |  |          |  |          |  |          |  |
| EXAMINER'S NAME (Type)   |         | Benedict Skitarelic, M.D.  |  |   |  |   |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)  |  | (State)                                 |  |                    |  |          |  |          |  |          |  |
| Burial   |         | JAN. 19, 1968  |  | St. Mary's Cemetery   |  | Cumberland, Md.   |  | Allegany  |  |   |  |                    |  |          |  |          |  |          |  |
| 24. FUNERAL DIRECTOR   |         | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |                    |  |          |  |          |  |          |  |
| James F. Scarpelli, Cumberland, Md.  |         |  |  | DATE  |  | JAN 23 1968   |  |   |  |   |  |                    |  |          |  |          |  |          |  |

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BOOK CO. 10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |  |
| 00051  |  |  |  |  | 00051  |  |  |  |  |  |
| 1. DECEASED NAME<br>(Type or print)  |  |  |  |  | First  |  | Middle   |  | Last   |  |
| Edna   |  |  |  |  | Irene  |  | Kertes   |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 2a. DATE OF DEATH  |  |
| Female   |  |  |  |  | White  |  | May 19, 1904   |  | Jan Month 13 Day 1988  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |
| Md.  |  |  |  |  | U.S.A.   |  |  |  | Allegany Md.   |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Westernport  |  |  |  |  | 430 Vine   |  | Waitress   |  | Restuarant   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| Md.  |  |  |  |  | Allegany   |  | Westernport  |  | 430 Vine   |  |
| 14. FATHER'S NAME  |  |  |  |  | First  |  | Middle   |  | Last   |  |
| Calvin   |  |  |  |  | Fazenbaker   |  | Lulu   |  | Seckman  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |
| no   |  |  |  |  |  |  | 140-16-7280A   |  | Robert Kertes Westernport, Md.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>  |  |  |  |  |  |  |  |  |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>   |  |  |  |  |  |  |  |  |  | 4 yrs  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |
| 4331   |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                      |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1968, to 1-13, 1968, that (I) (we) last saw the deceased alive on 1-13-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |
| James H. Wolverton   |  |  |  |  |  |  |  |  |  | 1-15-68  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |
| James H. Wolverton   |  |  |  |  | Piedmont, W. Va.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |
| Burial   |  |  |  |  | 1/16/68  |  | Philos   |  | Westernport Md.  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |
| G. J. Boal   |  |  |  |  | Westernport, Md.   |  |  | DATE JAN 17 1968   |  | Charles J. J...  |

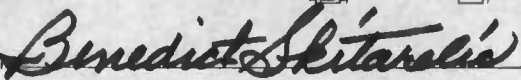
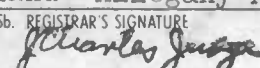
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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                              |  |  |      |   |      |   |  |
|--|---------|------------------------------|--|--|------|---|------|---|--|
| <div>00052</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00052</div>   |         |                              |  |  |      |   |      |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |      | 2a. DATE KNOWN OF DEATH   |      |   | 2b. HOUR                                     |
| Gerald F. Kumm   |         |                              |  |  |      | <input checked="" type="checkbox"/> Month Day Year<br>Jan. 7, 1968;                     |      |   | 4 AM   |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS.  |      | 2c. DATE PRONOUNCED DEAD  |  |
| Male   | White   | Nov. 22, 1903                | 64 YRS.  | MONTHS   | DAYS | HOURS   | MIN. | Jan. 7, 1968  | 194:30 AM                                    |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |      | 9. COUNTY OF DEATH  |      | Md.   |  |
| Penna.   |         | USA                          |  | <input type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input checked="" type="checkbox"/> DIVORCED |      | Allegany  |      |   |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                                       |  |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |      |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Cumberland   |         |                              | D.O.A. Memorial  |  |      | Excursion Dept.   |      |   | Textile                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |  |      | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS?  | 13e. STREET AND NUMBER                       |
| Md.  |         |                              | Allegany   |  |      | Cumberland  |      | <input checked="" type="checkbox"/> YES<br><input type="checkbox"/> NO                | 661 Mc Mullen Highway                        |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |  |      |   |      |   |  |
| George A. Kumm   |         |                              | Mary Frederick   |  |      |   |      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  |      | 17. INFORMANT ADDRESS   |      |   |  |
| no   |         |                              |  |  |      | Mrs. Le Roy Sheakley La Vale, Md. Sister  |      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |      |   |      |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4109</u> <b>Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |                              |  |  |      |   |      |   | Minutes<br>---                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |      |   |      |   |  |
| 19a. DATE OF OPERATION<br>4201   |         |                              |  |  |      |   |      |   |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |         |                              | 20. AUTOPSY?   |  |      |   |      |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |      |   |  |
|  |         |                              | HOUR A.M. P.M. 19  |  |      |   |      |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |  |      | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |      |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |      |   |      |   |  |
| ACTUAL SIGNATURE   |         |                              | CHIEF MEDICAL EXAMINER   |  |      | 22b. DATE SIGNED  |      |   |  |
|   |         |                              | <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER<br><input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER |  |      | January 7, 1968   |      |   |  |
| EXAMINER'S NAME (Type)   |         |                              | ADDRESS (Street, city, town, or county)  |  |      |   |      |   |  |
| BENEDICT SKITARELIC, M.D.  |         |                              | Cumberland, Maryland   |  |      |   |      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE                    |  | 23c. NAME OF CEMETERY OR CREMATORY   |      | 23d. LOCATION (City or Town) (County) (State)   |      |   |  |
| Burial   |         | Jan. 10, 1968                |  | Hillcrest Burial Park  |      | Cumberland Allegany Md.   |      |   |  |
| 24. FUNERAL DIRECTOR'S ADDRESS   |         |                              |  |  |      | 25a. REC'D BY REGISTRAR   |      | 25b. REGISTRAR'S SIGNATURE  |  |
| James F. Scarpelli, Cumberland, Md.  |         |                              |  |  |      | JAN 11 1968   |      |  |  |

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Jan. 7, 1958

Jan. 7, 1958

Continuation

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Continuation

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Jan 11 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00053

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00053

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>LENA PASQUALINE LAGRATTA LACROTTA</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>26</b> Year <b>1968</b>        |   |  | 2b. HOUR<br><b>4PM M</b>  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br><b>4-20-1897</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>70</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>ITALY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>MEMORIAL HOSPITAL HWFE.</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>OWN HOME</b>   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>OWN HOME</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission)<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>ALLEGANY</b>  |   | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>133 WEST THIRD STREET</b>  |  |   |   |   |  |   |  |
| 14. FATHER'S NAME<br>First <b>VINCENT</b> Middle <b>LASSERRA</b> Last <b>Philomenia</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Philomenia</b> Middle <b></b> Last <b></b> |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b></b>   |   | 17. INFORMANT<br>Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b><br><b>410.9</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Myocarditis</b><br>(c) <b></b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b><br><b>2 yrs</b> |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION<br><b></b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>   |   | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br><b></b>                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b></b>  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)<br><b></b>                        |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b></b>   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 20, 1968</b> , to <b>Jan 26, 1968</b> , that (I) (we) last<br>saw the deceased alive on <b>Jan 26, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Clay E. Durrett</b>  |  |   |   | DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  | 22c. DATE SIGNED<br><b>1-27-68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. CLAY E. DURRETT</b>  |  |   |   | 22e. ADDRESS<br><b>236 VIRGINIA AVE., CUMBERLAND, MD.</b>   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 29, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick's Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Md.</b>                               |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 30 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

00053

PASQUALINE

LA. ARROTIA

JANUARY 25 1968 1423

FEMALE WHITE

1920-1993

70

ITALY

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

1963

ALLEGANY

ALLEGANY CUMBERLAND X

133 WEST THIRD STREET

VINCENT

LASSEPPA

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. CLAY E. GURRETT

225 VIRGINIA AVE., CUMBERLAND, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |  |  |  |   |  |  |
| Item 8 Film G397 1/24/68 kk  |  |  |   |  |  |  |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br><b>VIVA</b>  |  |  | Middle<br><b>MAE</b>   |  |  | Last<br><b>LANCASTER</b>  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br><b>MAY 21, 1910</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>10</b> , Day <b>10</b> , Year <b>1968</b>                         |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                              |  |  | 6. AGE (In years last birthday)<br><b>57</b> YRS.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FROSTBURG</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MINERS HOSPITAL</b>  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSE WORK</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  |  | 13b. COUNTY<br><b>ALLEGANY</b>  |  |  | 13c. CITY OR TOWN<br><b>ECKHART</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First <b>GEORGE</b> Middle <b>RYAN</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>MERINDA</b> Middle <b>PORTER</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, na, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-12-8065</b>  |  |  |
| 17. INFORMANT<br>Address<br><b>MRS. SHEILA HANERICH, ECKHART, MD.</b>  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Bilateral Pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>486x</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b> |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>PRIMARY CARCINOMA OF CERVIX WITH METASTASES</b> |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 9, 1968</b> , to <b>JAN 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>JAN 10, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>G. Paige Strong</b>   |  |  |   |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  | 22c. DATE SIGNED<br><b>JAN 11, 1968</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>A. PAIGE STRONG, M. D.</b>  |  |  |   |  |  | 22e. ADDRESS<br><b>E. MAIN ST., FROSTBURG, MD. 21532</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>1-13-68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ECKHART CEMETERY</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ECKHART, MD.</b>                            |  |  |
| 24. FUNERAL DIRECTOR<br><b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 15 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |

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TO ALL  
 HONORABLE  
 MEMBERS  
 OF THE  
 HOUSE OF REPRESENTATIVES  
 WASHINGTON, D.C.  
 DEAR MR. [Name]  
 I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the [Name] and to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
 [Signature]  
 [Name]  
 [Title]  
 [Address]

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|  |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
|--|---------|------------------------------|--|--|------------------------------------|---|--|--|-----------------------------------|----------------------------|----------|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |                                    | 2a. DATE KNOWN OF DEATH   |  |  | Month Day Year                    |                            |          | 2b. HOUR                                     |  |  |
| William A. Lange   |         |                              |  |  |                                    | JAN. 7, 1968  |  |  | 2:40                              |                            |          |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |                                    | IF UNDER 24 HRS.  |  | 2c. DATE PRONOUNCED DEAD   |                                   |                            | 2d. HOUR |  |  |  |
| Male   | White   | July 2, 1918                 | 49 YRS.  | MONTHS   | DAYS                               | HOURS   | MIN.   | January 7, 1968  |                                   |                            | 2:50A M  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |  |  |                                   |                            |          |  |  |  |
| Maryland   |         | U. S. A.                     |  |  |                                    | Allegany Md.  |  |  |                                   |                            |          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                            |          |  |  |  |
| Cumberland   |         |                              | Memorial Hospital  |  |                                    | Bakery Employee   |  |  | Bakery                            |                            |          |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |                            |          |  |  |  |
| Maryland   |         |                              | Allegany   |  | Cumberland                         |   |  |  | 418 Bond St.                      |                            |          |  |  |  |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| Ralph A. Lange   |         |                              | Annabelle ManHel   |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT ADDRESS   |  |  |                                   |                            |          |  |  |  |
| yes  |         |                              | WWII   |  |                                    | Ralph Lange Cumberland Md.  |  |  |                                   |                            |          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                              |  |  |                                    |   |  |  |                                   |                            |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 1. DEATH WAS CAUSED BY:   |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| IMMEDIATE CAUSE (a) Lobar Pneumonia, Bilateral   |         |                              |  |  |                                    |   |  |  |                                   |                            |          | 4-5 Days                                     |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 481X  |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| (c)  |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| Emphysema, very marked. EPILEPSY   |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| 19a. DATE OF OPERATION   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |                            |          |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |                              |  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19   |                                    |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                   |                            |          |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |                                    |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                     |                                   |                            |          |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |                                    |   |  |  |                                   |                            |          |  |  |  |
| ACTUAL SIGNATURE   |         |                              |  | Benedict Skitarelic M.D.   |                                    |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                  |                                   |                            |          | 22b. DATE SIGNED                             |  |  |
| EXAMINER'S NAME (Type)   |         |                              |  | BENEDICT SKITARELIC, M.D.  |                                    |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                      |                                   |                            |          | January 7, 1968                              |  |  |
|  |         |                              |  |  |                                    |   |  | ADDRESS (Street, city, town, or county)  |                                   |                            |          | Cumberland, Maryland                         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION (City or Town) (County) (State)                                    |                                   |                            |          |  |  |  |
| Burial   |         |                              | 1/10/68  |  | Rose Hill Cemetery                 |   |  | Cumberland Allegany Md.  |                                   |                            |          |  |  |  |
| 24. FUNERAL DIRECTOR   |         |                              |  | ADDRESS  |                                    |   |  | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE |          |  |  |  |
| Louis Stein Inc.   |         |                              |  | Cumb. Md.  |                                    |   |  | JAN 11 1968  |                                   | Charles Judge              |          |  |  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00056

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00056

|  |                         |  |  |  |   |   |  |   |
|--|-------------------------|--|--|--|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or Print) <b>Jack Burnett Lanum</b>  |                         |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>1 15 1968</b> |  |   | 2b. HOUR <b>6:10</b> M  |  |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Jan. 29, 1934</b>                                     | 6. AGE (In years last birthday) <b>33</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>  | 2c. DATE PRONOUNCED DEAD<br>Month <input type="checkbox"/> Day <b>15</b> Year <b>1968</b>                                   |  |   |
| 7a. BIRTHPLACE (State or foreign country) <b>Ohio Painesville</b>  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED: <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Allegheny Co.</b> Md.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Sacred Heart Hospital</b>                       |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>V. Pres. Cumberland Steel</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |                         |  | 13b. COUNTY <b>Allegheny</b>   |  | 13c. CITY OR TOWN <b>Cumberland</b>   |   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 14. FATHER'S NAME<br>First <b>Burnett</b> Middle <b>Lanum</b> Last <b>Lanum</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Pauline</b> Middle <b>Fletcher</b> Last <b>Fletcher</b>                                       |  |   | 13e. STREET AND NUMBER<br><b>Longwood Drive 1033</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>282-30-7929</b>   |  | 17. INFORMANT<br><b>Mrs. Donna Lanum</b>  |   |  | ADDRESS<br><b>1033 Longwood Ave. Cumb.</b> Md.                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109 CORONARY THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4109</b><br>(b) <b>CORONARY SCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b>  |                         |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>SUDDEN</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>47201</b>  |                         |  |  |  |   |   |  |   |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b>                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |  | County  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |  |   |   |  |   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   | 22b. DATE SIGNED  |  |   |
| EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>  |                         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   | <b>January 15, 1968</b>   |  |   |
| ADDRESS (Street, city, town, or county) <b>Cumberland, Maryland</b>  |                         |  |  |  |   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>1/18/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Riverside Cemetery</b>                  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Painesville, Lake, Ohio</b>   |  |   |
| 24. FUNERAL DIRECTOR<br><b>H. Wayne George</b>   |                         |  |  | ADDRESS<br><b>202 Greene St. Cumberland, Md.</b>                                 |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 17 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                          |  |  |  |  |   |                   |
|--|--|--|--------------------------|--|--|--|--|---|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                          |  |  |  |  |   |                   |
| CERTIFICATE OF DEATH   |  |  |                          |  |  |  |  |   |                   |
| 00057  |  |  |                          |  |  |  |  |   |                   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First                    | Middle   | Last   | 2a. DATE OF DEATH<br>Month Day Year  |  |   | 2b. HOUR A        |
| JOHN   |  |  | H                        |  | LEASURE  | JANUARY 9 1968   |  |   | 4:30 <sup>M</sup> |
| 3. SEX   |  | 4. RACE  |                          | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                   |
| MALE   |  | WHITE  |                          | 12-5-1892  |  | 75 YRS.  |  |   |                   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |                   |
| PENNA.   |  | U.S.A.   |                          |  |  | ALLEGANY Md.   |  |   |                   |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |                   |
| CUMBERLAND, MD.  |  | MEMORIAL HOSPITAL  |                          | Retired Conductor  |  | Railroad   |  |   |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |                   |
| MARYLAND   |  | ALLEGANY   |                          | CUMBERLAND   |  |  |  | 131 GRAND AVENUE  |                   |
| 14. FATHER'S NAME  |  |  | First                    | Middle   | Last   | 15. MOTHER'S MAIDEN NAME   |  |   | First Middle Last |
| GEORGE   |  |  |                          |  | LEASURE  | SARAH LOTTIG   |  |   | WOLKES            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. |  |  | 17. INFORMANT Address  |  |   |                   |
| no   |  |  |                          |  |  | MEMORIAL HOSPITAL, CUMBERLAND, MD.   |  |   |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4120</u> <u>Coronary heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>443X</u> |  |  |                          |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 months</u><br><u>10 years</u><br><u>10 years</u> |                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Dissecting aneurysm of the aorta - spontaneously aneurysm</u> <u>Diabetes</u>   |  |  |                          |  |  |  |  |   |                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                   |
|  |  |  |                          |  |  |  |  |   |                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |                   |
|  |  |  |                          |  |  |  |  |   |                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County State  |                   |
|  |  |  |                          |  |  |  |  |   |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> , 19 <u>58</u> , to <u>1/9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                          |  |  |  |  |   |                   |
| 22b. SIGNATURE<br><u>S. G. Weisman</u>   |  |  |                          |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>1/12/68</u>                                   |   |                   |
| 22d. PHYSICIAN'S NAME (Type)<br><u>DR. S. G. WEISMAN</u>   |  |  |                          |  | 22e. ADDRESS<br><u>59 GREENE ST., CUMBERLAND, MD.</u>  |  |  |   |                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |                   |
| Burial   |  | Jan. 10, 1968  |                          | Sunset Memorial Park   |  | Cumberland, Md. Allegany   |  |   |                   |
| 24. FUNERAL DIRECTOR<br><u>James F. Scarpelli, Cumberland, Md.</u>   |  |  |                          |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 16 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |   |                   |

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CUMBERLAND, MD.

CENTRAL HOSPITAL

BARVAND

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GEORGE

LEASING

SARAH E. M. KOTLER

NEUROLOGICAL HOSPITAL, CUMBERLAND, MD.

DR. S. G. WEISMAN

29 GREENE ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 00058   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                     |                 |   |               | 00058   |  |
| CERTIFICATE OF DEATH  |  |   |                 |   |               |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First<br>MARTHA | Middle<br>M.  | Last<br>LEWIS | 2a. DATE OF DEATH<br>JAN. Month 26 Day 1968 Year  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |                 | 5. DATE OF BIRTH<br>JUNE 15, 1889   |               | 6. AGE (In years last birthday)<br>78 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                 | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 9. COUNTY OF DEATH<br>ALLEGANY Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>FROSTBURG  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>MINERS HOSPITAL |                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSE WORK   |               | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>ALLEGANY   |                 | 13c. CITY OR TOWN<br>FROSTBURG  |               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>116 ORMOND ST.  |  | 14. FATHER'S NAME<br>First Middle Last<br>GEORGE COOK   |                 | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>MARTHA MEYRICK   |               |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.<br>216-10-1325   |                 | 17. INFORMANT<br>Address<br>OLIVER G. LEWIS, FROSTBURG, MD. 21532   |               |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4120 Arterio-Sclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443 X (b) Hypertensive Cardio-vascular disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Senility<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 years<br>20 years |  |   |                 |   |               |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Generalized arthritis   |  |   |                 |   |               |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |               | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                      |                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |               |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |                 | 21f. LOCATION Street or R.F.D. No. City or Town County State  |               |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-18, 1968, to 1-26, 1968, that (I) (we) last saw the deceased alive on 1-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |                 |   |               |   |  |
| 22b. SIGNATURE<br>H.C. Diehl, M.D.  |  | 22c. DATE SIGNED<br>1-27-68   |                 | 22d. PHYSICIAN'S NAME (Type)<br>H. C. DIEHL, M. D.  |               |   |  |
| 22e. ADDRESS<br>39 W. MAIN ST., FROSTBURG, MD.  |  |   |                 |   |               |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>JAN. 28, 1968  |                 | 23c. NAME OF CEMETERY OR CREMATORY<br>F.B.G. MEMORIAL PARK  |               | 23d. LOCATION (City or Town) (County) (State)<br>FROSTBURG, MD.                                 |  |
| 24. FUNERAL DIRECTOR<br>JOSEPH R. DURST, SR., FROSTBURG, MD. 21532  |  | 25a. REC'D BY REGISTRAR<br>DATE JAN 30 1968   |                 | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |               |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00059

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED-NAME (Type or print)<br>First Middle Last<br><b>Minnie G. Light</b>  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>Jan. 13, 1968</b>                                     |  | 2b. HOUR<br><b>4:15</b> P. M.                                    |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>10/7/1881</b>  |   | 6. AGE (In years lost birthday)<br><b>86</b> YRS.    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Allegany</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Allegany County Infirmary</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>Allegany</b>   | 13c. CITY OR TOWN<br><b>Cumberland</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>418 N. Mechanic St.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Andy Ours</b>  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elizabeth Borrer</b>  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  | 16b. SOCIAL SECURITY NO.<br><b>213-24-5455-T</b>   | 17. INFORMANT <b>P.O. Box 599, Cumberland, Md.</b><br><b>Allegany County Infirmary records.</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b><br><b>4369</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>331x</b>   |  |   |   |  |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 7, 1967</b> , to <b>Jan. 13, 1968</b> , that (I) (we) lost the deceased on <b>Jan. 13, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>George M. Simons M.D.</b>   |  | DEGREE<br><b>M.D.</b>   | ATTENDING PHYS.<br><input checked="" type="checkbox"/>  | MED. DIRECTOR<br><input checked="" type="checkbox"/> | STAFF PHYS.<br><input checked="" type="checkbox"/>               |
| 22c. PHYSICIAN'S NAME (Type)<br><b>George M. Simons M.D.</b>   |  | 22e. ADDRESS<br><b>Memorial Hospital, Cumberland, Md.</b>   |   | 22d. DATE SIGNED<br><b>1/15/68</b>                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>1/16/68</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Md</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br><b>Louis Stein Inc. Cumb. Md.</b>  |  | ADDRESS   | 25a. REC'D BY REGISTRAR<br>DATE <b>19 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |   |  |   |  |
|---|--|--|---|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Anna Bernstein Lipson</b>   |  |  |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>January 25, 1968</b> |   |  | 2b. HOUR<br><b>4:05 M</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>July 4, 1877</b>   |  | 6. AGE (In years last birthday)<br><b>90</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Allegheny</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Allegheny Co. Infirmary</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Allegheny</b>  |   | 13c. CITY OR TOWN<br><b>Maryland</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>787 Fayette Street</b>                                 |  |
| 14. FATHER'S NAME First Middle Last<br><b>Morris Bernstein</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mollie Mendelson</b> |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT <b>P.O. Box 599, Cumberland, Md.</b><br><b>Allegheny County Infirmary records.</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4450</b> <i>Fracture of left leg 4 feet</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4501</b> <i>Arteriosclerosis - Generalized</i><br>(b) <i>Arteriosclerosis obliterans - Lt leg</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Fracture of Rt. hip (nonunion) Senile psychosis</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Fracture of Rt. hip (nonunion) Senile psychosis</i> |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>25 days</b><br><i>many years</i> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 30, 1968</b> to <b>Jan. 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>Jan. 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE <i>John A. Tepper</i> M.D.   |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>       |  | 22c. DATE SIGNED<br><b>1/25/1968</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>John A. Tepper M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>Memorial Hospital, Cumberland, Md.</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Jan. 26, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>East View Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegheny Md.</b>                |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 30 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |                        |  |
|--|--|--|--|--|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |                        |  |
| 00061  |  |  |  |  |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                                     |                        |  |
| BOYD   |  |  | FRANKLIN LOHR  |  |  | JAN 22 68   |  | 12:10 PM                                     |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                              |                        |  |
| MALE   |  | WHITE  |  | 11-16-93   |  | 74 YRS.   |  | MONTHS DAYS HOURS MIN                        |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                        |  |
| MARYLAND   |  | U.S.A.   |  |  |  | ALLEGANY Md.  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                        |  |
| CUMBERLAND   |  |  | MEMORIAL HOSPITAL  |  |  | FARMER  |  | INDUSTRY FARMING                             |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| MARYLAND   |  |  | GARRETT  |  | SWANTON  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | RT. 2                  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |  |                        |  |
| First Middle Last  |  |  | First Middle Last  |  |  |   |  |  |                        |  |
| ALFORD * * *   |  |  | LOHR   |  |  | SUSAN * * * O'BRIEN   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |  |                        |  |
| NO   |  |  |  |  | MEMORIAL HOSPITAL CUMBERLAND, MD.  |   |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 485X BRONCHO-PNEUMONIA-TERMINAL   |  |  |  |  |  |   |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 497X  |  |  |  |  |  |   |  |  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |  |                        |  |
| GLOMERULO NEPHRITIS-AC & CHR -- HEMOPTYSIS   |  |  |  |  |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                     |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 5, 19 68, to JAN 22, 19 68, that (I) (we) last saw the deceased alive on JAN. 22, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |                        |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY   |  |  |  |  | 22e. ADDRESS   |   | 1/24/68  |  |                        |  |
| 22e. ADDRESS   |  |  |  |  | LA VALE, MD.   |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| BURIAL   |  | 1/26/68  |  | BRENNEMAN CEMETERY   |  | GARRETT COUNTY MARYLAND   |  |  |                        |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. RECD BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                        |  |
| Gerald N. Minnich  |  | OAKLAND, MARYLAND  |  | DATE FEB 5 1968  |  | Charles Judge   |  |  |                        |  |

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MALE WHITE 11-10-23  
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MEMORIAL HOSPITAL  
CHURCHLAND, MD  
BRONCHIO-PNEUMONIA-TERMINAL

ENTER TO REPORTS-AC & CHD - MEMORIALS  
YES

JAN 23 08 12:10  
DR. THOMAS E. LUSBY  
LA VALE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |   |  |  |                                      |
|---|--|--|---|---|--|---|--|--|--------------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |   |  |  |                                      |
| CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |  |                                      |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last<br>ROBERT W LOVE                            |   |  | 2a. DATE OF DEATH<br>Month Day Year<br>JANUARY 8 1968   |  | 2b. HOUR<br>11 P M   |                                      |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |   | 5. DATE OF BIRTH<br>8-25-1874   |  | 6. AGE (In years<br>lost birthday)<br>93 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                       |                                      |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>SCOTLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>ALLEGANY Md.  |  |  |                                      |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND, MD.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>MEMORIAL HOSPITAL |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>PHYSICIAN   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>W. VA.  |  | 13b. COUNTY<br>MOOREFIELD  |   | 13c. CITY OR TOWN<br>MOOREFIELD   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |                                      |
| 14. FATHER'S NAME<br>First Middle Last<br>HUGH LOVE   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>GEMIN WALTER |   |  |   |  |  |                                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.                                      |   | 17. INFORMANT<br>Address<br>MEMORIAL HOSPITAL, CUMBERLAND, MD.                       |   |  |  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Cardiac failure</u><br><u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pneumonia Rt. lower lobe, acute</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>A.S. Cardiovascular disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3 hours</u><br><u>10 days.</u><br><u>5 years</u> |                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>4221</u> <u>Chronic pulmonary emphysema &amp; fibrosis</u>  |  |  |   |   |  |   |  |  |                                      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?        |  |                                      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |                                      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                      |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County State   |                                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>30 Dec.</u> , 19 <u>67</u> , to <u>8 Jan 68</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>8 Jan 68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |  |                                      |
| 22b. SIGNATURE<br><u>W. A. Van Ormer, M.D.</u>  |  |  |   |   | DEGREE ATTENDING<br>PHYS.  |   | MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>8 Jan. 68</u> |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>DR. W. A. VAN ORMER  |  |  |   |   | 22e. ADDRESS<br>122 S. CENTRE ST., CUMBERLAND, MD.                                   |   |  |  |                                      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE<br><u>1-11-68</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Olivet Cemetery</u>  |  | 23d. LOCATION (City or Town)<br><u>Moorefield</u>   |  | (County) (State)<br><u>Hardy W Va</u>  |                                      |
| 24. FUNERAL DIRECTOR<br><u>Charles B. Warrick - Moorefield W Va</u>   |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 12 1968</u>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                             |  |                                      |

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122 S. CUMBERLAND, PA.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00063

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00063

|  |  |  |                    |   |  |   |                            |   |  |
|--|--|--|--------------------|---|--|---|----------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>VIRGIL</b>   | Middle<br><b>D</b> | Last<br><b>LOWERY</b>   | 2a. DATE OF DEATH<br>Month Day Year<br><b>JAN 9 68</b> |   | 2b. HOUR<br><b>11:55</b> M |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |                    | 5. DATE OF BIRTH<br><b>6-19-07</b>  |  | 6. AGE (In years last birthday)<br><b>60</b> YRS.   |                            | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENNA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ALLEGANY COUNTY</b> Md.  |                            |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Celanese employee</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Texttiles</b>   |                            |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>PENNA.</b>   |  | 13b. COUNTY<br><b>BEDFORD</b>  |                    | 13c. CITY OR TOWN<br><b>HYNDMAN</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 13e. STREET AND NUMBER<br><b>RXXXXX RT. 1</b> |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>NOAH LOWERY</b>   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>ANNIE CLITES</b>                                     |                    |   |  |   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-07-1947</b>   |                    | 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>   |  | Address<br><b>CUMBERLAND, MD.</b>   |                            |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis</b><br><b>185X</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Prostatic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 yrs.</b> |  |  |                    |   |  |   |                            |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>177X</b>   |  |  |                    |   |  |   |                            |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                    | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                            |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |                            |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |                            |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/1/68</b> , to <b>1/9/68</b> , that (I) (we) last saw the deceased alive on <b>1/9/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                    |   |  |   |                            |   |  |
| 22b. SIGNATURE<br><b>Walter N. Himmler</b>   |  | 22c. DATE SIGNED<br><b>1/10/68</b>   |                    | 22d. PHYSICIAN'S NAME (Type) <b>DR. W. A. HIMMLER</b>   |  |   |                            |   |  |
| 22e. ADDRESS<br><b>CUMBERLAND, MD.</b>   |  |  |                    |   |  |   |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>Jan. 12, 1968</b>  |                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Porter Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Hyndman, Pa. RD#1</b>                       |                            |   |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>H arvey H. Zeigler, Hyndman, Pa.</b>   |  |  |                    | 25a. REC'D BY REGISTRAR<br>DATE<br><b>JAN 15 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Indge</b>  |                            |   |  |

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|            |                   |         |        |                |
|------------|-------------------|---------|--------|----------------|
| MALE       | WHITE             | 8-12-07 | LOWERY | JAN 3 11 11 11 |
| PENNA.     | U.S.A.            |         |        |                |
| CUMBERLAND | GENERAL HOSPITAL  |         |        |                |
| PENNA.     | BEDEFORD HOSPITAL |         |        |                |
| LOWERY     | ANNIE             |         |        |                |
| MALE       | WHITE             | 8-12-07 | LOWERY | JAN 3 11 11 11 |
| PENNA.     | U.S.A.            |         |        |                |
| CUMBERLAND | GENERAL HOSPITAL  |         |        |                |
| PENNA.     | BEDEFORD HOSPITAL |         |        |                |
| LOWERY     | ANNIE             |         |        |                |

DR. W. A. HUNTER  
CUMBERLAND, MD.

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00064

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00064

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Edward A. Mackert</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>January</b> Day <b>21</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>6:10 PM</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>May 4 1873</b>   |  | 6. AGE (In years last birthday)<br><b>94</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. COUNTY OF DEATH<br><b>Allegany</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cumberland</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Allegany Infirmary</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Allegany</b>  |  | 13c. CITY OR TOWN<br><b>Cumberland</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  |
| 13e. STREET AND NUMBER<br><b>242 N. Mechanic Street</b>  |  | 14. FATHER'S NAME First Middle Last<br><b>Cassain A. Mackert</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Lydinger</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)<br><b>Unknown</b> |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mrs. L. A. Gordon, Cumberland, Md.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>yes</b><br><b>yes</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4200</b>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>George M. Simons, M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/26/68</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>George M. Simons</b>   |  | 22e. ADDRESS<br><b>Memorial Hospital, Cumberland, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 24, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SS. Peter &amp; Paul Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 25 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|   |  |  |                |   |                |   |  |
|---|--|--|----------------|---|----------------|---|--|
| 00065   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                          |                |   |                | 00065   |  |
| CERTIFICATE OF DEATH  |  |  |                |   |                |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>LEWIS | Middle<br>G   | Lost<br>MANGUS | 2a. DATE OF DEATH<br>Month JAN 22 Year 1968 12:15 P   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |                | 5. DATE OF BIRTH<br>3-17-87   |                | 6. AGE (In years<br>lost 80 day) YRS.   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>GARRETT, PA.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                | 9. COUNTY OF DEATH<br>ALLEGANY Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>MEMORIAL HOSPITAL |                | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>B&O RR  |                | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE PA   |  | 13b. COUNTY<br>BEDFORD   |                | 13c. CITY OR TOWN<br>HYNDMAN  |                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER  |  | 14. FATHER'S NAME<br>First GRANT Middle MANGUS Lost  |                | 15. MOTHER'S MAIDEN NAME<br>First BARBARA Middle Spangler Lost  |                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) NO   |  | (If yes give war or dates of service)  |                | 16b. SOCIAL SECURITY NO.<br>705-09-9030   |                | 17. INFORMANT<br>Address<br>MEMORIAL HOSPITAL CUMBERLAND, MD.                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Constrictive heart failure - left</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4200</u><br>(b) <u>arteriosclerosis &amp; pulmonary heart</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerotic disease of lungs, cause?</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hours</u><br><u>5 yr</u><br><u>2</u> |  |  |                |   |                |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Influenza</u> <u>Aggravated by 106° +</u>  |  |  |                |   |                |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                      |                | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>68</u> , to <u>1/22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                |   |                |   |  |
| 22b. SIGNATURE<br><u>Charles Judge</u>  |  |  |                | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |                | 22c. DATE SIGNED<br><u>1/23/68</u>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DR. B. SCHINDLER  |  |  |                | 22e. ADDRESS<br>CUMBERLAND, MD.   |                |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>Jan. 25, 1968   |                | 23c. NAME OF CEMETERY OR CREMATORY<br>Hyndman Cemetery  |                | 23d. LOCATION (City or Town) (County) (State)<br>Hyndman, Bedford Co., Pa.                      |  |
| 24. FUNERAL DIRECTOR<br>Harvey H. Zeigler, Hyndman, Pa.   |  |  |                | 25a. REC'D BY REGISTRAR<br>DATE JAN 29 1968   |                | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

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LEWIS G MAR 22 JAN 22 6842:12

MALE WHITE 3-17-27 ALLEGANY BARRETT, PA. U.S.A.

CONFERLAND MEMORIAL HOSPITAL BLD WY BEDFORD HYDRAULIC

GRANT MARBLE BARRETT CONFERLAND, PA. TOP-02-0030 MEMORIAL HOSPITAL

[Faint, illegible text and markings, possibly a large stamp or signature]

CONFERLAND, PA. NO. 8. SCHMITZ

Bedford Co., Pa. Jan. 22, 1922 HANSEN COMPANY HANSEN H. Bedford Co., Pa.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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VR A15  
30M REV. 1-64

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |   |                                    |   |   |  |                        |        |         |
|--|--|------------------------------|--|---|------------------------------------|---|---|--|------------------------|--------|---------|
| CERTIFICATE OF DEATH   |  |                              |  |   |                                    |   |   |  |                        |        |         |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First  | Middle  | Last                               | 2a. DATE OF DEATH   |   |  | 2b. HOUR               |        |         |
| THOMAS   |  |                              | L.   |   | MC CUSKER                          | JAN 7 68  |   |  | 11:30 AM               |        |         |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                    | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |                        |        |         |
| MALE   |  | WHITE                        |  | 7-3-79  |                                    | 88 YRS.   |   |  |                        |        |         |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |  |                        |        |         |
| HANCOCK, MD  |  | U.S.A.                       |  |   |                                    | ALLEGANY COUNTY Md.   |   |  |                        |        |         |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                        |        |         |
| CUMBERLAND   |  |                              | MEMORIAL HOSPITAL  |   |                                    | FARMING   |   |  |                        |        |         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?                      |  | 13e. STREET AND NUMBER |        |         |
| MD.  |  |                              | ALLEGANY   |   | LITTLE ORLEANS                     |   | NO <input type="checkbox"/>                   |  |                        |        |         |
| 14. FATHER'S NAME  |  |                              | First  | Middle  | Last                               | 15. MOTHER'S MAIDEN NAME  |   |  | First                  | Middle | Last    |
| ABNER  |  |                              |  |   | MC CUSKER                          | SARA  |   |  |                        |        | BRIDGES |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  |                              | 16b. SOCIAL SECURITY NO.   |   |                                    | 17. INFORMANT   |   |  | Address                |        |         |
| NO   |  |                              | 216 46 9684  |   |                                    | J1 CECELIA I MCCUSKER   |   |  | LITTLE ORLEANS MD      |        |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary heart failure</i><br><i>4129</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Arteriosclerotic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Brachitis, viral type, probably influenza</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>12h</i><br><i>10y</i><br><i>12h</i> |  |                              |  |   |                                    |   |   |  |                        |        |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>481x</i>   |  |                              |  |   |                                    |   |   |  |                        |        |         |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |        |         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |                        |        |         |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |                        |        |         |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/7/68</i> , 19 <i>60</i> , to <i>1/7/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>1/7/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                              |  |   |                                    |   |   |  |                        |        |         |
| 22b. SIGNATURE<br><i>S. G. Weisman</i>   |  |                              |  |   |                                    | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><i>1/8/68</i>                                    |                        |        |         |
| 22d. PHYSICIAN'S NAME (Type)<br>DR. S. G. WEISMAN  |  |                              |  |   |                                    | 22e. ADDRESS<br>CUMBERLAND, MD.   |   |  |                        |        |         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State) |  |                        |        |         |
| BURIAL   |  |                              | 1.10.78  |   | ST. PATRICKS                       |   | LITTLE ORLEANS ALLEGANY MD                    |  |                        |        |         |
| 24. FUNERAL DIRECTOR<br><i>Howard J. Stone Hancock &amp; mol</i>   |  |                              |  |   |                                    | 25a. REC'D BY REGISTRAR<br>DATE JAN 15 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |                        |        |         |

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THOMAS L. MC CUSKER JAN 7 88 11:30

MALE WHITE 7-3-79 88

HANDCOCK, MD. U.S.A. ALLEGANY COUNTY

GREENLAND VENERIAL HOSPITAL

NO. 1 LITTLE OCEANS

ABER MC CUSKER SARA BRIDGES

NO. 1 LITTLE OCEANS

NO. 1 LITTLE OCEANS

NO. 1 LITTLE OCEANS

NO. 1 LITTLE OCEANS

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NO. 1 LITTLE OCEANS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |  |        |   |  |  |  |  |                         |
|--|--|--|--------|---|--|--|--|--|-------------------------|
| 1. DECEASED-NAME<br>(Type or print) <b>LAURA</b>   |  | First <b>V.</b>  | Middle | Lost  | 2a. DATE OF DEATH<br>Month <b>JAN</b> Day <b>28</b> Year <b>68</b>   |  | 2b. HOUR<br><b>10:25 PM</b>  |  |                         |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |        | 5. DATE OF BIRTH<br><b>1-8-1895</b>   |  | 6. AGE (In years<br>lost birthday) <b>73</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                         |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>PENNA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |        | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ALLEGANY CO.</b>  |  |  | MD.                     |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) <b>MEMORIAL HOSPITAL</b> |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) <b>HWF.</b>  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  |                         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>PA.</b>  |  | 13b. COUNTY <b>Bedford</b>   |        | 13c. CITY OR TOWN <b>CLEARVILLE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>RD # 2</b>  |                         |
| 14. FATHER'S NAME<br><b>FRANK</b>  |  | First  | Middle | Lost  | 15. MOTHER'S MAIDEN NAME<br><b>EMMA</b>  |  | First  | Middle                                   | Lost<br><b>STECKMAN</b> |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b>  |  | (If yes give war or dates of service)  |        | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br>Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>                |  |  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Infectious Hepatitis</b><br><b>070x</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>093x</b><br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Since 12-16-67</b> |  |  |        |   |  |  |  |  |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arteriosclerotic Cardiovascular disease</b>  |  |  |        |   |  |  |  |  |                         |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                         |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                         |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                          |        |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                         |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-16-67</b> to <b>1-26-68</b> , that (I) (we) lost saw the deceased alive on <b>1-26-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |        |   |  |  |  |  |                         |
| 22b. SIGNATURE <b>W.F. Williams</b>  |  |  |        |   | DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-27-68</b>                                   |  |                         |
| 22d. PHYSICIAN'S NAME (Type)<br><b>W.F. WILLIAMS, MD.</b>  |  |  |        |   | 22e. ADDRESS<br><b>122 S. CENTRE ST., CUMBERLAND, MD.</b>  |  |  |  |                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>1/29/68</b>  |        | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Everett Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Everett, Bedford Co., Pa.</b>    |  |  |                         |
| 24. FUNERAL DIRECTOR<br><b>Lyndel Bonner</b>   |  | ADDRESS<br><b>Everett, Pa.</b>   |        | 25a. REC'D BY REGISTRAR<br><b>EEB</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                   |  | DATE<br><b>1 1968</b>                    |                         |

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REVEREND FATHER, CUMBERLAND, MD.

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151 S. CENTRE ST., CUMBERTLAND, MD.

W. J. HILL, JR.

V E R T I C A L

$\frac{1}{\sqrt{2}} \left( \begin{matrix} 1 & -i \\ i & 1 \end{matrix} \right)$

• 1954, 1955, 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113 (10)  
30M REV. 1/68

|   |  |  |       |  |      |  |      |
|---|--|--|-------|--|------|--|------|
| 00068   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |       |  |      | 00068  |      |
| CERTIFICATE OF DEATH  |  |  |       |  |      |  |      |
| 1. DECEASED-NAME (Type or print)  |  |  | First | Middle   | Lost | 2a. DATE OF DEATH  |      |
| Martha Maude Michael  |  |  |       |  |      | Month  | Day  |
|   |  |  |       |  |      | Jan  | 8    |
|   |  |  |       |  |      | Year   | 1968 |
|   |  |  |       |  |      | 3  | P    |
|   |  |  |       |  |      | M  |      |
| 3. SEX  |  | 4. RACE  |       | 5. DATE OF BIRTH   |      | 6. AGE (In years lost birthday)  |      |
| Female  |  | White  |       | Dec. 8, 1883   |      | 84 YRS.  |      |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |       | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH   |      |
| Maryland  |  | U S A  |       |  |      | Allegany Md.   |      |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      | 12b. KIND OF BUSINESS OR INDUSTRY  |      |
| Frostburg   |  | Miners Hospital  |       | Housewife  |      | Home   |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |       | 13c. CITY OR TOWN  |      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      |
| Maryland  |  | Allegany   |       | Frostburg  |      | 91 Pine Street   |      |
| 14. FATHER'S NAME   |  |  | First | Middle   | Lost | 15. MOTHER'S MAIDEN NAME   |      |
| Peter   |  |  |       |  |      | Maryann  |      |
|   |  |  |       |  |      | Workman  |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown   |  | 16b. SOCIAL SECURITY NO.   |       | 17. INFORMANT  |      |  |      |
| No  |  | 220-46-3745  |       | Miners Hospital Frostburg, Maryland  |      |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |       |  |      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |      |
| PART I. DEATH WAS CAUSED BY:  |  |  |       |  |      | 12-12-67.  |      |
| IMMEDIATE CAUSE (a) Cerebral Hemorrhage   |  |  |       |  |      |  |      |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |       |  |      |  |      |
| (b) Hypertensive Cardio-vascular disease  |  |  |       |  |      | 5 yrs.   |      |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |       |  |      |  |      |
| (c)   |  |  |       |  |      |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |       |  |      |  |      |
| 443X Senility   |  |  |       |  |      |  |      |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |       | 20a. AUTOPSY?  |      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |      |
|   |  |  |       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      |  |      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |  |      |
|   |  | HOUR A.M. Month Day Year   |       |  |      |  |      |
|   |  | P.M. 19  |       |  |      |  |      |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |       | 21f. LOCATION  |      |  |      |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  |  |       | Street or R.F.D. No. City or Town County State   |      |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10, 1967, to 1-8, 1968, that (I) (we) last saw the deceased alive on 1-8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |       |  |      |  |      |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |       | 22d. PHYSICIAN'S NAME (Type)   |      |  |      |
| H.C. Diehl  |  | 1/9/68   |       | H.C. Diehl, M.D.   |      |  |      |
| 22e. ADDRESS  |  | 22f. ADDRESS   |       | 22g. ADDRESS   |      |  |      |
| Frostburg, Md.  |  | Frostburg, Md.   |       | Frostburg, Md.   |      |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |       | 23c. NAME OF CEMETERY OR CREMATORY   |      | 23d. LOCATION (City or Town) (County) (State)  |      |
| Burial  |  | Jan. 10, 1968  |       | Mt. Zion Church Cemetery   |      | Near Grantsville Garrett Md.   |      |
| 24. FUNERAL DIRECTOR  |  | 24a. ADDRESS   |       | 25a. REC'D BY REGISTRAR  |      | 25b. REGISTRAR'S SIGNATURE   |      |
| John J. Hafer, Jr.  |  | 230 Balto Ave.,  |       | Cumberland   |      | Charles Judge  |      |
|   |  |  |       | JAN 11 1968  |      |  |      |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-15 (4)  
30M REV. 1/68

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 00069   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201              |   |   |  | 00069  |  |  |  |
| Items 12a & b Film G397 2/8/68 kk CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last                             |   |  | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR<br>M  |  |
| Jacob T.  |  |  | Miller  |   |  | January 4  |  | 1968   |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                           |  |
| Male  |  | White  |   | March 4, 1893   |  | 74 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN                            |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Maryland  |  | U.S.A.   |   |   |  | Allegany Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)             |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Cumberland  |  | Memorial Hospital  |   | Custodian Retired   |  | Bank   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                                   |  |
| Maryland  |  | Allegany   |   | Midland   |  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last |   |  |  |  |  |  |
| Henry Miller  |  |  | Anna Nicol                                    |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address  |  |  |  |  |  |
| no  |  | 217-05-5091  |   | Lee Miller Lonaconing, Md.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PERITONITIS</u><br><u>575X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>585X</u><br>(b) <u>RUPTURED GANGRENOUS GALL BLADDER</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><u>Cerebral Aneurysm</u> <u>Arterio Sclerosis</u> <u>Cardiomegaly</u> |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1</u> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>              |  |  |  |
| <u>X</u>  |  | <u>X</u>   |   | <u>X</u>  |  | <u>Yes</u>   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING,<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>                        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><u>X</u>   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><u>X</u> |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><u>X</u> <u>X</u> <u>X</u> <u>X</u>   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 1967</u> , to <u>1/4, 1968</u> , that (I) (we) last saw the deceased alive on <u>1/3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>SG Weisman</u>   |  | 22c. DATE SIGNED<br><u>1/5/68</u>  |   | 22d. PHYSICIAN'S NAME (Type)<br><u>SG WEISMAN MD</u>  |  |  |  |  |  |
| 22e. ADDRESS<br><u>59 GREENE ST CUMBERLAND MD</u>   |  |  |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>1/7/1968</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Sunset Memorial Park</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Cumberland Allegany, Md</u>              |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>George Eichhorn</u>  |  | 25a. REC'D BY REGISTRAR<br><u>JAN 8 1968</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>J Charles Judge</u>  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Robert</b> <b>Olson</b> <b>Miller</b>  |  | 2a. DATE OF DEATH<br>Jan <sup>Month</sup> 7 <sup>Day</sup> 1968 <sup>Year</sup>                      |  | 2b. HOUR<br>11.20M  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>Feb. 19, 1888</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>West Va. Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Westernport</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wood St. Ext.</b> |  | 9. COUNTY OF DEATH<br><b>Allegany</b> Md.   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Allegany</b>   |  | 13c. CITY OR TOWN<br><b>Westernport</b>   |  |
| 14. FATHER'S NAME<br><b>Jefferson</b> <b>Miller</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Amanada</b> <b>Michael</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>no</b> (If yes give war or dates of service)   |  |
| 16b. SOCIAL SECURITY NO.<br><b>236-14-1056</b>  |  | 17. INFORMANT<br><b>Myrtle Miller</b>  |  | Address<br><b>Westernport, Md.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>428x Cardiac Insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>chronic Myocarditis</b><br>(b) <b>chronic Myocarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Day</b><br><b>10 Years</b> |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4222</b>  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 29, 1967</b> , to <b>Jan 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>Jan 7, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Paul R. Wilson M.D.</b>  |  |  |  | 22c. DATE SIGNED<br><b>Jan 8, 1968</b>  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>  |  |  |  | 22e. ADDRESS<br><b>Piedmont, W. Va.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/10/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Philos</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>E. J. Boal</b>   |  | Address<br><b>Westernport, Md.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Westernport, Allegany- Md.</b>  |  |
| 25a. REC'D BY REGISTRAR<br><b>JAN 11 1968</b>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00071

|   |         |                              |   |   |   |  |                                |     |   |   |  |
|---|---------|------------------------------|---|---|---|--|--------------------------------|-----|---|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First                        | Middle  | Last  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |  | Month                          | Day | Year  | 2b. HOUR  |  |
| Charles   |         | E.                           | Moffatt   |   | JAN. 19, 1968                             |  |                                |     | 19  | 8:00 A.M.   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             |   | 6. AGE (in years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS            |  | IF UNDER 24 HRS.<br>HOURS MIN. |     | 2c. DATE PRONOUNCED DEAD<br>Month Day Year  |   |  |
| M   | W       | 6/12/1916                    |   | 51 YRS.   |   |  |                                |     | January 19, 1968 8:00 A.M.  |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |                                |     |   |   |  |
| Md.   |         | U.S. A.                      |   |   |   | Allegany Md.   |                                |     |   |   |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |                                |     | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |
| Lonaconing  |         |                              | 68 Jackson St.  |   |   | Twister  |                                |     | Celanese Co.  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         |                              | 13b. COUNTY   |   |   | 13c. CITY OR TOWN  |                                |     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| Md.   |         |                              | Allegany  |   |   | Lonaconing   |                                |     | 68 Jackson Street   |   |  |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME  |   |   |  |                                |     |   |   |  |
| Richard   |         |                              | Moffatt   |   |   | Mary   |                                |     | Howell  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.  |   |   | 17. INFORMANT  |                                |     | ADDRESS   |   |  |
| Yes   |         |                              | W.W. 11   |   |   | 217-10-5827  |                                |     | Elsie Moffatt Lonaconing, Md.   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. } (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |                              |   |   |   |  |                                |     |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>SUDDEN |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |                              |   |   |   |  |                                |     |   |   |  |
| 4109  |         |                              |   |   |   |  |                                |     |   |   |  |
| 19a. DATE OF OPERATION  |         |                              | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |   |   |  |                                |     | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                    |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |                                |     |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |   |   | 21f. LOCATION Street or R.F.D. No.   |                                |     | City or Town County State   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |   |   |   |  |                                |     |   |   |  |
| ACTUAL<br>SIGNATURE   |         |                              | Benedict Skitarelic   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                |     | 22b. DATE SIGNED  |   |  |
| EXAMINER'S<br>NAME (Type)   |         |                              | BENEDICT SKITARELIC, M.D.   |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                                |     | January 19, 1968  |   |  |
|   |         |                              |   |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                |                                |     | ADDRESS (Street, city, town, or county) UMBERLAND, MARYLAND                                     |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         |                              | 23b. DATE   |   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                |     | 23d. LOCATION (City or Town) (County) (State)   |   |  |
| Burial  |         |                              | 1/22/68   |   |   | Frostburg Mem. Park  |                                |     | Frostburg All. Md.  |   |  |
| 24. FUNERAL DIRECTOR  |         |                              |   |   |   | ADDRESS  |                                |     | 25a. REC'D BY REGISTRAR   |   |  |
| W. Harold Fredlock Jr. Piedmont, W.V.   |         |                              |   |   |   |  |                                |     | JAN 23 1968   |   |  |
|   |         |                              |   |   |   |  |                                |     | 25b. REGISTRAR'S SIGNATURE  |   |  |
|   |         |                              |   |   |   |  |                                |     | f. J. J. J.   |   |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |  |      |  |      |  |  |
|---|---------|--|--|--|------|--|------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |  |      |  |      |  |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  |  | Middle   |      | Last   |      | 2a. DATE KNOWN OF DEATH                                    |  |
| George  |         | -Eanz  |  | Edward   |      | Moore  |      | <input checked="" type="checkbox"/> Month<br>Jan. 29 19 68 |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS.   |      | 2c. DATE PRONOUNCED DEAD                                   |  |
| Male  | White   | June 15, 1882  | 85 YRS.  | MONTHS   | DAYS | HOURS  | MIN. | January 29 19 68 12:45                                     |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH   |      |  |  |
| Maryland  |         | U.S.A.   |  |  |      | Allegany Md.   |      |  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      | 12b. KIND OF BUSINESS OR INDUSTRY  |      |  |  |
| Cumberland  |         | Memorial Hospital  |  | Farmer   |      | Farm   |      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |      | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |      | 13e. STREET AND NUMBER                                     |  |
| Md.   |         | Allegany   |  | Barton   |      |  |      | rural  |  |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME   |  |      |  |      |  |  |
| Henry Moore   |         |  | Ellen Duckworth  |  |      |  |      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |  |      | 17. INFORMANT ADDRESS  |      |  |  |
| Yes No  |         |  | 220-52-9469  |  |      | Mrs Arvada Porter Barton, Md.  |      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u><br><u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4221</u><br>(b) <u>Arteriosclerotic Cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Months</u><br>----- |         |  |  |  |      |  |      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Frostbite of both feet</u>  |         |  |  |  |      |  |      |  |  |
| 19a. DATE OF OPERATION  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |      | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |      |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                    |  |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |      |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |      | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |      |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |         |  |  |  |      |  |      |  |  |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u>   |         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |  |      | 22b. DATE SIGNED   |      |  |  |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.  |         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                          |  |      | January 29, 1968   |      |  |  |
|   |         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |  |      | ADDRESS (Street, city, town, or county) <u>Cumberland, Maryland</u>                          |      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |      | 23d. LOCATION (City or Town) (County) (State)  |      |  |  |
| Burial  |         | 1/31/68  |  | Moore Cemetery   |      | Barton Md.   |      |  |  |
| 24. FUNERAL DIRECTOR <u>E. J. Boul</u>  |         |  | ADDRESS <u>Westernport, Md.</u>  |  |      | 25a. REC'D BY REGISTRAR DATE <u>JAN 30 1968</u>  |      | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>              |  |

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                         |   |  |   |  |   |  |
|--|-------------------------|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |                         | First<br><b>Ellen</b>   | Middle<br><b>M.</b>                              | Last<br><b>Nicol</b>  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> Month Day Year<br>MATED <input type="checkbox"/> <b>1/8/1968</b> |   | 2b. HOUR<br><b>M</b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>12/11/1914</b>   |  | 6. AGE (In years last birthday)<br><b>53</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>Jan, 8 1968</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | 9. COUNTY OF DEATH<br><b>Allegany</b>   |  |
| 1d. CITY OR TOWN OF DEATH<br><b>Lonaconing</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Charlestown, ST.</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>                         |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD.</b>  |                         | 13b. COUNTY<br><b>Allegany</b>  |  | 13c. CITY OR TOWN<br><b>Lonaconing</b>  |  | 13e. STREET AND NUMBER<br><b>Charlestown, St.</b>                                   |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>James Nicol</b>   |                         |   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Ida Timmney</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>John Nicol</b>  |  | ADDRESS<br><b>Lonaconing, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4109</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>---</b> |                         |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |                         |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |   |  | 2d. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>          |                         |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Benedict Skitarelic</b>   |                         | EXAMINER'S NAME (Type)<br><b>Benedict Skitarelic</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>1/8/1968</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>1/11/1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Hill Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Lonaconing, Md.</b>             |  |
| 24. FUNERAL DIRECTOR<br><b>George Eichhorn</b>   |                         |   |  | ADDRESS<br><b>Lonaconing, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 15 1968</b>                                  |  |
|  |                         |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |                |   |                                       |  |           |   |                   |
|---|--|--|--|---|----------------|---|---------------------------------------|--|-----------|---|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |                |   |                                       |  |           |   |                   |
| CERTIFICATE OF DEATH  |  |  |  |   |                |   |                                       |  |           |   |                   |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>DANIEL  |  | Middle<br>E   | Last<br>NORRIS |   | 2a. DATE OF DEATH<br>Month<br>JANUARY |  | Day<br>30 | Year<br>1968                                    | 2b. HOUR<br>12:45 |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>6-26-1875   |                | 6. AGE (In years<br>last birthday)<br>92  |                                       | IF UNDER 1 YEAR<br>MONTHS<br>DAYS          |           | IF UNDER 24 HRS<br>HOURS<br>MIN.                |                   |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>WASH. CO., MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                | 9. COUNTY OF DEATH<br>ALLEGANY Md.  |                                       |  |           |   |                   |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND, MD.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>MEMORIAL HOSPITAL |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>STONE MASON   |                | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>BUILDING  |                                       |  |           |   |                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MD.   |  | 13b. COUNTY<br>ALLEGANY  |  | 13c. CITY OR TOWN<br>MT. SAVAGE   |                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                       | 13e. STREET AND NUMBER<br>ROUTE 1, BOX 143 |           |   |                   |
| 14. FATHER'S NAME<br>First<br>DANIEL  |  | Middle<br>NORRIS   |  | Last<br>EASTON  |                | 15. MOTHER'S MAIDEN NAME<br>First<br>SARAH  |                                       | Middle<br>EASTON                           |           | Last<br>EASTON                                  |                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>NONE   |  | 17. INFORMANT<br>Address<br>MEMORIAL HOSPITAL, CUMBERLAND, MD.  |                |   |                                       |  |           |   |                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction &amp; Congestive heart failure</u><br><u>410.9</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>410.9</u><br>(b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>acute femoral occlusion - left - due to embolus</u> |  |  |  |   |                |   |                                       |  |           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                   |
| 19a. DATE OF OPERATION<br><u>1/28/68</u>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Left Femoral Thrombectomy</u>                 |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |                                       |  |           |   |                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                |   |                                       |  |           |   |                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.)                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                |   |                                       |  |           |   |                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/12/68</u> , 19 <u>68</u> , to <u>1/30/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/30/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.  |  |  |  |   |                |   |                                       |  |           |   |                   |
| 22b. SIGNATURE<br><u>W. Himmler</u>   |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/>   |                | MED. DIRECTOR <input type="checkbox"/>  |                                       | STAFF PHYS. <input type="checkbox"/>       |           | 22c. DATE SIGNED<br><u>2/1/69</u>               |                   |
| 22d. PHYSICIAN'S NAME (Type)<br>DR. WALTER HIMMLER  |  | 22e. ADDRESS<br>412 N. MECHANIC ST., CUMBERLAND, MD  |  |   |                |   |                                       |  |           |   |                   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>FEB. 2, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. SAVAGE METHODIST CEM.   |                | 23d. LOCATION (City or Town) (County) (State)<br>MT. SAVAGE ALLEGANY MD.                        |                                       |  |           |   |                   |
| 24. FUNERAL DIRECTOR<br>BYRON KIGHT   |  | ADDRESS<br>CUMBERLAND, MD.   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 6 1968  |                | 25b. REGISTRAR'S SIGNATURE<br><u>Francis Judge</u>  |                                       |  |           |   |                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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|   |         |  |                  |   |   |  |  |   |          |
|---|---------|--|------------------|---|---|--|--|---|----------|
| 1. DECEASED-NAME<br>(Type or print)   |         | First  | Middle           | Lost  | 2a. DATE OF DEATH   |  | 2b. HOUR   |   |          |
| ALPHARETTA  |         | K.   |                  | PARKER  | JANUARY 31 1968   |  | 10:40 P.M.   |   |          |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR  |   |          |
| FEMALE  | WHITE   |  | 12-29-1910       |   | 57 YRS.   |  | MONTHS DAYS HOURS MIN.   |   |          |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |          |
| MARYLAND  |         | U.S.A.   |                  |   |   | ALLEGANY Md.   |  |   |          |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |          |
| CUMBERLAND  |         | MEMORIAL HOSPITAL  |                  | SCHOOL TEACHER  |   |  |  |   |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 13e. STREET AND NUMBER  |          |
| MARYLAND  |         | ALLEGANY   |                  | CUMBERLAND  |   |  |  | 571 PATTERSON AVE.  |          |
| 14. FATHER'S NAME   |         | First  | Middle           | Lost  | 15. MOTHER'S MAIDEN NAME  |  | First  | Middle  | Lost     |
| WILLIAM   |         |  |                  | KING  | LILLIE  |  |  |   | CRAWFORD |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |         | (If yes give war or dates of service)  |                  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address  |  |   |          |
|   |         |  |                  |   |   | MEMORIAL HOSPITAL, CUMBERLAND, MD.   |  |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>174X</u> <u>Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Carcinoma Right Breast</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Carcinomatous</u>   |         |  |                  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>7 days</u><br><u>4 mns</u><br><u>6 wks</u> |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>170X</u>  |         |  |                  |   |   |  |  |   |          |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |          |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |   |          |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>Jan 31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 31</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |                  |   |   |  |  |   |          |
| 22b. SIGNATURE<br><u>Clay Durrett</u>   |         | DEGREE   |                  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |   | 22c. DATE SIGNED<br><u>2/1/68</u>  |  |   |          |
| 22d. PHYSICIAN'S NAME (Type)<br>DR. CLAY DURRETT  |         | 22e. ADDRESS<br>CUMBERLAND, MD.  |                  |   |   |  |  |   |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |         | 23b. DATE<br>2/3/68  |                  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest Burial Park   |   | 23d. LOCATION (City or Town) (County) (State)<br>Cumberland, Allegany, Md.                   |  |   |          |
| 24. FUNERAL DIRECTOR  |         | ADDRESS  |                  | 25a. REC'D BY REGISTRAR<br>FEB 7 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |          |
| Philip B. Wendt   |         | 121 Memorial Ave. Cumb. Md.  |                  |   |   |  |  |   |          |

00075

00075

CRIMINAL RECORDS

18-30-1910  
FARMER  
JANUARY 21 10:40  
WHITE  
FEMALE

ALLEGANY

WYOMING

MEMORIAL HOSPITAL  
SCHOOL TEACHER

WYOMING  
ALLEGANY  
CUMBERLAND  
571 PATTERSON AVE.

CRANFORD  
LILLIE  
KING  
FEMALE

MEMORIAL HOSPITAL, CUMBERLAND, MD.

CUMBERLAND, MD.

DR. C. A. CORRETT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |  |                                   |                        |  |
|--|--|--|--|--|---|--|--|-----------------------------------|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |                                   |                        |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |                                   |                        |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |                        |  |
| Ferdinand Ravenscroft  |  |  |  |  | Jan, 25 <sup>th</sup> . 1968  |  |  | Year                              |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                   |                        |  |
| Male   |  | White  |  | 8/9/1890   |   | 77 YRS.  |  | MONTHS DAYS HOURS MIN.            |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   |                        |  |
| MD.  |  | USA.   |  |  |   | Allegany Md.   |  |                                   |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  | 12b. KIND OF BUSINESS OR INDUSTRY |                        |  |
| Frostburg  |  |  | Miners Hospital  |  |   | Retired Coal Miner   |  |                                   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER |  |
| Md.  |  |  | Allegany   |  | Lonaconing  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                                   | HKnkamp, St.           |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |                                   |                        |  |
| John T. Ravenscroft  |  |  | Mary Swauger   |  |   |  |  |                                   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |  |                                   |                        |  |
| No   |  |  |  |  | Rachael Ravenscroft, Lonaconing, Md.  |  |  |                                   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |  |  |                                   |                        |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |  |  |                                   |                        |  |
| IMMEDIATE CAUSE (a) <u>Ca of prostate</u>  |  |  |  |  |   |  |  |                                   |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Ca Liver</u>  |  |  |  |  |   |  |  |                                   |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>   |  |  |  |  |   |  |  |                                   |                        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |   |  |  |                                   |                        |  |
| 177X   |  |  |  |  |   |  |  |                                   |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |   |  |  |                                   |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |                                   |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21</u> , 19 <u>68</u> , to <u>1/25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/25/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |                                   |                        |  |
| 22b. SIGNATURE   |  | 22c. PHYSICIAN'S NAME (Type)   |  |  | 22d. ADDRESS  |  | 22e. DATE SIGNED   |                                   |                        |  |
| John B. Davis, MD  |  | John B. Davis, MD  |  |  | 22 Broadway, Frostburg, Md  |  | 1/26/68  |                                   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |                        |  |
| Burial   |  | 1/27/1968  |  | Oak Hill Cemetery  |   | Lonaconing, Md.  |  |                                   |                        |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                                   |                        |  |
| George Eichhorn  |  | Lonaconing, Md.  |  |  | DATE JAN 29 1968 Charles Judge  |  |  |                                   |                        |  |

00076

00076

CENTRAL OF DEATH

1901, 1902, 1903

1904, 1905, 1906

1907, 1908, 1909

1910

1911, 1912, 1913

1914, 1915, 1916

1917, 1918, 1919

1920, 1921, 1922

1923, 1924, 1925

1926, 1927, 1928

1929, 1930, 1931

1932, 1933, 1934

1935, 1936, 1937

1938, 1939, 1940

1941, 1942, 1943

1944, 1945, 1946

1947, 1948, 1949

1950, 1951, 1952

1953, 1954, 1955

1956, 1957, 1958

1959, 1960, 1961

1962, 1963, 1964

1965, 1966, 1967

1968, 1969, 1970

1971, 1972, 1973

1974, 1975, 1976

1977, 1978, 1979

1980, 1981, 1982

1983, 1984, 1985

1986, 1987, 1988

1989, 1990, 1991

1992, 1993, 1994

1995, 1996, 1997

1998, 1999, 2000

2001, 2002, 2003

2004, 2005, 2006

2007, 2008, 2009

2010, 2011, 2012

2013, 2014, 2015

2016, 2017, 2018

2019, 2020, 2021

2022, 2023, 2024

2025, 2026, 2027

2028, 2029, 2030

2031, 2032, 2033

2034, 2035, 2036

2037, 2038, 2039

2040, 2041, 2042

2043, 2044, 2045

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00077

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00077

|  |  |                  |                                     |   |  |   |  |  |                                    |   |  |   |  |   |                  |   |  |  |  |       |  |
|--|--|------------------|-------------------------------------|---|--|---|--|--|------------------------------------|---|--|---|--|---|------------------|---|--|--|--|-------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |                  | First<br>Joseph                     |   |  | Middle<br>Reed  |  |  | Last                               |   |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Jan. 6 1968 |  |   | 2b. HOUR<br>3:15 |   |  |  |  |       |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |                                     | 5. DATE OF BIRTH<br>Apr. 19, 1875   |  | 6. AGE (In years<br>last birthday)<br>92 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                    | IF UNDER 24 HRS<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>January 6, 1968   |  |   | 2d. HOUR<br>4:15 |   |  |  |  |       |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>W. Va.   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Allegany Md. |   |  |   |  |   |                  |   |  |  |  |       |  |
| 10. CITY OR TOWN OF DEATH<br>Flintstone  |  |                  |                                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Rt. 2 Flintstone |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Retired Farmer |                                    |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Own Farm  |  |   |                  |   |  |  |  |       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  |                  |                                     | 13b. COUNTY<br>Allegany   |  |   |  | 13c. CITY OR TOWN<br>Flintstone  |                                    | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>Route 2, Flintstone, Md.  |  |   |                  |   |  |  |  |       |  |
| 14. FATHER'S NAME<br>First<br>Unknown  |  |                  |                                     |   |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Unknown  |  |  |                                    |   |  |   |  |   |                  |   |  |  |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>no  |  |                  |                                     | (If yes give war or dates of service)   |  |   |  | 16b. SOCIAL SECURITY NO.   |                                    |   |  | 17. INFORMANT<br>Mrs. James Watson, Flintstone, Md.                                       |  |   |                  | ADDRESS<br>Daughter                                       |  |  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |                                     |   |  |   |  |  |                                    |   |  |   |  |   |                  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 Days |  |  |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>490X</u>  |  |                  |                                     |   |  |   |  |  |                                    |   |  |   |  |   |                  |   |  |  |  |       |  |
| 19a. DATE OF OPERATION   |  |                  |                                     |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?  |  |  |                                    |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |   |                  |   |  |  |  |       |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |                  |                                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                              |                                    |   |  |   |  |   |                  |   |  |  |  |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                  |                                     | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)                     |  |   |  | 21f. LOCATION Street or R.F.D. No.   |                                    |   |  | City or Town  |  |   |                  | County  |  |  |  | State |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                  |                                     |   |  |   |  |  |                                    |   |  |   |  |   |                  |   |  |  |  |       |  |
| ACTUAL<br>SIGNATURE <u>Benedict Skitarelic</u> M.D.  |  |                  |                                     |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |                                    |   |  | 22b. DATE SIGNED<br>January 6, 1968   |  |   |                  |   |  |  |  |       |  |
| EXAMINER'S<br>NAME (Type) BENEDICT SKITARELIC, M.D.  |  |                  |                                     |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |                                    |   |  | ADDRESS (Street, city, town, or village)<br>Cumberland, Maryland                          |  |   |                  |   |  |  |  |       |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |                  |                                     | 23b. DATE<br>Jan. 9, 1968   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Davis Memorial Cemetery  |                                    |   |  | 23d. LOCATION (City or Town) (County) (State)<br>Cumberland Allegany Md.                  |  |   |                  |   |  |  |  |       |  |
| 24. FUNERAL DIRECTOR<br>James F. Scarpelli, Cumberland, Md.  |  |                  |                                     |   |  |   |  |  |                                    | 25a. REC'D BY REGISTRAR<br>DATE JAN 11 1968   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |                  |   |  |  |  |       |  |

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*Handwritten signature or text.*

*Handwritten text at the bottom left.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|---------------------|--|--|--|
| 00078  |  |  |  |   |  |   |  |   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |  |  |  | 00078   |  |  |  |  |  |                     |  |  |  |
| Item 6 Film G396 1/12/68 kk  |  |  |  |   |  |   |  |   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |   |  | First<br>WILLIAM  |  |   |  |  |  | Middle<br>BURK  |  |  |  |  |  | Last<br>REID   |  |   |  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>JAN 2 68 |  |  |  |  |  | 2b. HOUR<br>11:35 A |  |  |  |
| 3. SEX<br>MALE   |  |  |  | 4. RACE<br>WHITE  |  |   |  | 5. DATE OF BIRTH<br>5-3-97  |  |  |  | 6. AGE (In years<br>last birthday)<br>70 11 YRS.  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN.          |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>GARRETT COUNTY, MD   |  |  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>ALLEGANY Md.   |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND  |  |  |  |   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>MEMORIAL HOSPITAL                                      |  |   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>LABORER   |  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>TRUCKING     |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND   |  |  |  |   |  | 13b. COUNTY<br>allegany   |  |   |  |  |  | 13c. CITY OR TOWN<br>WESTERNPORT  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br>MAIN ST. EXT. |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>JOSEPH P REID  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>ELLA WILT  |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give year or dates of service)<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>WW 1  |  |  |  |   |  | 16b. SOCIAL SECURITY NO.<br>215 10 8067   |  |   |  |  |  | 17. INFORMANT<br>MEMORIAL HOSPITAL  |  |  |  |  |  | Address<br>CUMBERLAND, MD.                           |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic Myeloid Leukemia</u><br>2051<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>2091</u> |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>? |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
|  |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Diabetes Mellitus</u>  |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                      |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)       |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                          |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-20-1967</u> to <u>1-2-1968</u> , that (I) (we) last saw the deceased alive on <u>1-2-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 22b. SIGNATURE<br><u>W. F. Williams</u>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |   |  |  |  | 22c. DATE SIGNED<br><u>1-4-68</u>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DR. W. F. WILLIAMS   |  |  |  |   |  | 22e. ADDRESS<br>CUMBERLAND, MD.   |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  |  |  | 23b. DATE<br><u>1/5/68</u>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BLOOMINGTON CEM.<br>ADDRESS<br>WESTERNPORT, Md. |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BLOOMINGTON GARRETT Md.  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>E. J. Boral</u>   |  |  |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>JAN 8 1968   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |                     |  |  |  |

00073

00073

CERTIFICATE OF DEATH

NAME: WILLIAM GURK REID DATE: JAN 3 1973

SEX: MALE RACE: WHITE

BIRTH: 1-1-27 ALLEGANY COUNTY, MD U.S.A.

DEATH: 1-3-73 MEMORIAL HOSPITAL

PLACE: HARRISBURG, MD

CAUSE: HEART DISEASE

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

DR. WILLIAMS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00079

CERTIFICATE OF DEATH

00079

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br>Harry Lawson Renwick  |   |  | 2a. DATE OF DEATH<br>Month Day Year<br>Jan. 24, 1968  |  | 2b. HOUR<br>M  |
| 3. SEX<br>M  | 4. RACE<br>W  | 5. DATE OF BIRTH<br>Jan. 19, 1909  |   | 6. AGE (In years last birthday)<br>59 YRS.       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>Penna.  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Allegheny Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Frostburg   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Miners Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Supt. Harrison-Walker                                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Refractoria |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   | 13b. COUNTY<br>Garrett  | 13c. CITY OR TOWN<br>Grantsville   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER                           |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Thomas Staley Renwick  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Sarah Poorman   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |   | 16b. SOCIAL SECURITY NO.<br>168-09-2686  | 17. INFORMANT<br>Address<br>Mrs. Louise Renwick, Grantsville, Md.                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASTROCYTOMA RIGHT TEMPORAL</u><br>1920 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>LOBE OF BRAIN WITH METASTASES</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 YEAR           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>1930  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br>Feb. 1967  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BRAIN TUMOR                                 | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, natly medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 14, 1968, to Jan 24, 1968, that (I) (we) last saw the deceased alive on Jan. 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |  |   |  |  |
| 22b. SIGNATURE<br>G. Paige Strong  |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>        | 22c. DATE SIGNED<br>Jan. 25, 1968   |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |   | 22e. ADDRESS   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE<br>Jan. 28, 1968  | 23c. NAME OF CEMETERY OR CREMATORY<br>Phillipsburg Cem.  | 23d. LOCATION (City or Town) (County) (State)<br>Phillipsburg Centre, Pa.                       |  |  |
| 24. FUNERAL DIRECTOR<br>Ruth Fleissman   | ADDRESS<br>Grantsville, Md.   |  | 25a. REC'D BY REGISTRAR<br>DATE<br>JAN 30 1968  | 25b. REGISTRAR'S SIGNATURE<br>Phyllis Judge      |  |

00070

00070

RECEIVED OF CASE

RECEIVED OF CASE

FEB 1957 BRAIN TUMOR

X

1/2 Page Strong

X

Jan 24 12 for 12 12 for 12

1/2 Page Strong

Asymptomatic Brain Tumor  
Lobe of Brain with Metastases 1 Year

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |                            |  |                  |  |
|---|--|--|--|--|--|--|--|----------------------------|--|------------------|--|
| 00080   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 00080  |  |                            |  |                  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH          |  | 2b. HOUR         |  |
| William   |  | Wayne  |  | Ritchie  |  |  |  | Jan Month 10 Day 1968 Year |  | 5A. M            |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR            |  | IF UNDER 24 HRS. |  |
| Male  |  | White  |  | April 23, 1910   |  | 51 YRS.  |  | MONTHS                     |  | DAYS             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                            |  |                  |  |
| West Va.  |  | U.S.A.   |  |  |  | Allegany Md.   |  |                            |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |                            |  |                  |  |
| Westernport   |  | 218 Green St.  |  | Foreman  |  | Paper Mill   |  |                            |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET AND NUMBER     |  |                  |  |
| Md.   |  | Allegany   |  | Westernport  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 218 Green St.              |  |                  |  |
| 14. FATHER'S NAME   |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME   |  | First            |  |
| David   |  | Ritchie  |  |  |  |  |  | Bessie                     |  | Foltz            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |                            |  |                  |  |
| No  |  |  |  | 216-09-3311  |  | Edna Ritchie Westernport, Md.  |  |                            |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |  |  |  |                            |  |                  |  |
| PART 1. DEATH WAS CAUSED BY:  |  | instant  |  |  |  |  |  |                            |  |                  |  |
| IMMEDIATE CAUSE (a)   |  | Myocardial Infarction  |  |  |  |  |  |                            |  |                  |  |
| 4109  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |                            |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  | (b) Atherosclerosis  |  |  |  |  |  |                            |  |                  |  |
|   |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |                            |  |                  |  |
|   |  | (c)  |  |  |  |  |  |                            |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | 4201   |  |  |  |  |  |                            |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                            |  |                  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |                            |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                            |  |                  |  |
|   |  | HOUR A.M. Month Day Year   |  |  |  |  |  |                            |  |                  |  |
|   |  | P.M. 19  |  |  |  |  |  |                            |  |                  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  |  |  |                            |  |                  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | Street or R.F.D. No. City or Town County State   |  |  |  |                            |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1967, to 1-10, 1968, that (I) (we) last saw the deceased alive on Jan 3, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                            |  |                  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. ADDRESS   |  |  |  |                            |  |                  |  |
| William W. Lesh M.D.  |  | 1-11-68  |  | Westernport, Md.   |  |  |  |                            |  |                  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |                            |  |                  |  |
| William W. Lesh   |  | Westernport, Md.   |  |  |  |  |  |                            |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)   |  | (County)                   |  | (State)          |  |
| Burial  |  | 1/13/68  |  | Philos   |  | Westernport  |  |                            |  | Md.              |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                            |  |                  |  |
| E. P. Beal  |  | DATE JAN 15 1968   |  | Charles Judge  |  |  |  |                            |  |                  |  |

02000

00000

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                         |  |  |   |   |  |  |   |  | 00081   |         |
|---|-------------------------|--|--|---|---|--|--|---|--|---|---------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |   |   |  |  |   |  | 00081   |         |
| 1. DECEASED-NAME<br>(Type or Print) <b>Wilbur Wilbert</b>   |                         |  | First Middle Last <b>Roberson</b>  |   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>1</b> Day <b>4</b> Year <b>1968</b> |  |   | 2b. HOUR <b>2:00</b> AM <input type="checkbox"/> PM <input type="checkbox"/> |   |         |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>8/9/1905</b>  | 6. AGE (In years last birthday)<br><b>62</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>                                 | 2c. DATE PRONOUNCED DEAD<br>Month <b>1st</b> Day <b>4th</b> Year <b>1968</b>                             |  |   | 2d. HOUR <b>9:00</b> AM <input type="checkbox"/> PM <input type="checkbox"/> |   |         |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Allegany</b>  |  |   | Md.  |   |         |
| 10. CITY OR TOWN OF DEATH<br><b>Midland</b>   |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Custodian</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Bank</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bank</b>                             |   |         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |                         |  | 13b. COUNTY <b>Allegany</b>  |   | 13c. CITY OR TOWN <b>Midland</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>*</b>   |   |         |
| 14. FATHER'S NAME<br>First Middle Last <b>Wilbur Wilbert Roberson</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last <b>Margaret Edwards</b>                            |   |   |  |  |   |  |   |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>2 War</b>   |   | 17. INFORMANT<br><b>Agnes Roberson</b>  |  |  | ADDRESS<br><b>Midland, Md. (Wife)</b>   |  |   |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>4109</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Coronary Sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>---</b>  |                         |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4201</b>  |                         |  |  |   |   |  |  |   |  |   |         |
| 19a. DATE OF OPERATION  |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |         |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M. <b>19</b>                       |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |   |  |   |         |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |   | County   |   | State   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |   |  |  |   |  |   |         |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b>   |                         |  | M.D.   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   | 22b. DATE SIGNED<br><b>1/4/1968</b>  |   |         |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic Cumberland, Md.</b>   |                         |  |  |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |   |         |
|   |                         |  |  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |   |         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>1/6/1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park</b>  |   |  | 23d. LOCATION (City or Town)<br><b>Frostburg, Md.</b>  |   | (County)   |   | (State) |
| 24. FUNERAL DIRECTOR<br><b>George Eichhorn</b>  |                         |  |  |   |   | ADDRESS<br><b>Lonaconing, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 8 1968</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>            |         |

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• *del. m. 1000000*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |   |        |   |                          |   |   |
|---|--|---|--------|---|--------------------------|---|---|
| 00082   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201     |        |   |                          | 00082   |   |
| 1. DECEASED-NAME<br>(Type or print)   |  | First   | Middle | Last  | 2a. DATE OF DEATH        |   | 2b. HOUR  |
| ORA   |  | K.  |        | ROBERTSON   | 1 Month 17 Day 1968      |   | 11A-M   |
| 3. SEX  |  | 4. RACE   |        | 5. DATE OF BIRTH  |                          | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.       |
| Female  |  | White   |        | 3/15/1908   |                          | 59 YRS.   |   |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. COUNTY OF DEATH  |   |
| MD.   |  | USA.  |        |   |                          | Allegany Md.  |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |        | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                          | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |
| Lonaconing  |  | Front ST.   |        | None  |                          |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                          | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| MD.   |  | Allegany  |        | Lonaconing  |                          | Front St.   |   |
| 14. FATHER'S NAME   |  | First   | Middle | Lost  | 15. MOTHER'S MAIDEN NAME |   | First Middle Lost                               |
| George Mowbray  |  |   |        |   | Amy Poland               |   |   |
| 16a. WAS DECEASED EVER<br>IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |                          |   |   |
| No  |  |   |        | George T. Robertson, Lonaconing, Md.  |                          |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |        |   |                          |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metabolic imbalance</u>  |  |   |        |   |                          |   | 2   |
| 1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>GI obstruction</u>   |  |   |        |   |                          |   | 3 months  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(c) <u>Ca of stomach (adenocarcinoma)</u>  |  |   |        |   |                          |   | 19 months                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |        |   |                          |   |   |
| 151X  |  |   |        |   |                          |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |        | 20a. AUTOPSY?   |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |
| 8-66  |  | Ca of stomach   |        | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                          |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                          |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                          |   |   |
|   |  |   |        |   |                          |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , to <u>1-15-1968</u> , that (I) (we) last<br>saw the deceased alive on <u>1-15-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |        |   |                          |   |   |
| 22b. SIGNATURE  |  |   |        | DEGREE  |                          | 22c. DATE SIGNED  |   |
| William W. Lesh   |  |   |        |   |                          |   |   |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  |   |        | 22e. ADDRESS  |                          |   |   |
| William W. Lesh   |  |   |        | Westernport, Maryland   |                          |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |                          | 23d. LOCATION (City or Town) (County) (State)   |   |
| Burial  |  | 1/20/1968   |        | Memorial Park   |                          | Frostburg, Md.  |   |
| 24. FUNERAL DIRECTOR  |  |   |        | ADDRESS   |                          | 25a. REC'D BY REGISTRAR<br>DATE   |   |
| George Eichhorn Lonaconing, Md.   |  |   |        |   |                          | 25b. REGISTRAR'S SIGNATURE<br>JAN 19 1968 Charles Judge   |   |

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VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |  |  |  |                                   |
|--|--|--|--|---|---|--|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |  |  |  |                                   |
| CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |                                   |
| 00083  |  |  |  |   |   |  |  |  |                                   |
| 1. DECEASED NAME<br>(Type or print)  |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH<br>Month Day Year  |  |  | 2b. HOUR<br>A M                   |
| RAYMOND  |  |  | D. ROBERTSON   |   |   | JANUARY 12 1968  |  |  | 4:50                              |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |  | 6. AGE (In years<br>lost birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |
| MALE   |  | WHITE  |  | NOVEMBER 28, 1898   |   |  | 69 YRS.  |  | IF UNDER 24 HRS<br>HOURS MIN      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  |                                   |
| MARYLAND   |  | U.S.A.   |  |   |   | ALLEGANY Md.   |  |  |                                   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| CUMBERLAND, MD.  |  |  | MEMORIAL HOSPITAL  |   |   | Retired Brick Setter   |  |  | Brick Ind.                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |
| MARYLAND   |  |  | ALLEGANY   |   | CUMBERLAND  |  |  |  | RT. #4, OLDTOWN ROAD              |
| 14. FATHER'S NAME<br>First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |   |  |  |  |                                   |
| ANDREW ROBERTSON   |  |  | MARTHA ROBEY   |   |   |  |  |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |  |  |  |                                   |
| no   |  |  |  |   | MEMORIAL HOSPITAL, CUMBERLAND, MD.  |  |  |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia -</u><br><u>470X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>470X</u><br>(b) <u>Acute Influenza</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic Bronchitis, Emphysema, - Silicosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>4 wks.</u><br><u>4 wks.</u><br><u>Years.</u> |  |  |  |   |   |  |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Arteriosclerotic Cardiovascular Disease - Cerebral Insufficiency</u>   |  |  |  |   |   |  |  |  |                                   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                   |
|  |  |  |  |   |   |  |  |  |                                   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |                                   |
|  |  |  |  |   |   |  |  |  |                                   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |                                   |
|  |  |  |  |   |   |  |  |  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>  </u> , to <u>Jan</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan 11</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |  |  |  |                                   |
| 22b. SIGNATURE<br><u>G. Overton Himmelwright</u>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |   | 22c. DATE SIGNED<br><u>1/13/68</u>   |  |  |                                   |
| 22d. PHYSICIAN'S NAME (Type)<br>DR. G. OVERTON HIMMELWRIGHT  |  |  |  | 22e. ADDRESS<br>133 VIRGINIA AVENUE, CUMBERLAND, MD.  |   |  |  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |                                   |
| Burial   |  | Jan. 14, 1968  |  | Mt. Herman Cemetery   |   | Cumberland, Allegany, Md.  |  |  |                                   |
| 24. FUNERAL DIRECTOR<br>James F. Scarpelli, Cumberland, Md.  |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE JAN 16 1968                               |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>  |  |                                   |

00083

00083

00083

ROBERTSON, R. RAYMOND - JANUARY 12, 1900

WHITE NOVEMBER 22, 1900

U.S.A. ALLEGANY

MEMORIAL HOSPITAL, CUMBERLAND, MD.

ALLEGANY, CUMBERLAND, MD.

ROBERTSON, RAYMOND

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. C. OVERSTEN, 133 VIRGINIA AVENUE, CUMBERLAND, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

| 00084  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 00084   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |   |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  |   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>   |  |  |  | d. STREET ADDRESS<br><b>915 GRAND AVE.</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARGARET</b> Middle <b>A.</b> Last <b>RODERICK</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>4</b> Year <b>19 68</b>   |  |   |  |   |  |   |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>OCTOBER 3, 1886</b>                                      |  | 9. AGE (In years last birthday) yrs. <b>81</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MINERAL CO., WEST VA.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>JAMES DUFFY</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>BRIDGET WARD</b>   |  |   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>HOSPITAL RECORD</b>   |  |   |  | Address   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>250.9 DUE TO <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260.8</b> DUE TO <b>DIABETES MELLITUS</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>GENERALIZED ARTERIOSCLEROSIS &amp; OSTEOARTHRITIS</b> |  |  |  | INTERVAL BETWEEN DEATH AND DEATH<br><b>3 DAYS</b><br><b>6 YRS.</b><br><b>6YRS.</b>  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>NONE</b>  |  |   |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, store, etc. bldg., etc.)<br><b>NONE</b>  |  | 20f. (City or town) (County) (State)  |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 4, 1968</b> to <b>JAN 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>JAN. 4, 1968</b> , and that death occurred at <b>2:45 AM</b> M, from causes and on the date stated above.  |  |  |  |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>James P. Hallinan M.D.</b>  |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> #  |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>     |  | 22b. DATE SIGNED<br><b>1-5-68</b>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JAMES P. HALLINAN, M.D.</b>   |  |  |  | 22d. ADDRESS<br><b>140 BEDFORD ST., CUMBERLAND, MD.</b>   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>Jan. 8, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SS. Peter &amp; Paul Cem.</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Md.</b> |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 11 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                              |  |   |  |   |  |

00004

ALLEGANY

CUMBERLAND

SACRED HEART HOSPITAL

MARGARET

WHITE

FEMALE

X

A.

ROBERTSON

OCTOBER 3, 1906

61

JANUARY 4

HILLMAN CO., WEST VA.

BRIDGET LANE

HOSPITAL RECORD

NO

ACUTE MYOCARDIAL INFARCTION

HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE

DISTENT VENTRICLES

GENERALIZED ARTERIOSCLEROSIS & OSTEOARTHRITIS

1 ONE

HOME

MAY 29, 1906

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1-2-50

JAMES P. HALLMAN, M.D.

110 BEDFORD ST., CUMBERLAND, MD.

MAY 1 1906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |         |   |                  |   |                                     |   |  |                        |  |
|--|---------|---|------------------|---|-------------------------------------|---|--|------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |         | First   | Middle           | Last  | 2a. DATE OF DEATH<br>Month Day Year |   | 2b. HOUR<br>M  |                        |  |
| LAURA MYRTLE ROSS  |         |   |                  |   | JAN. 17 1968                        |   |  |                        |  |
| 3. SEX   | 4. RACE |   | 5. DATE OF BIRTH |   | 6. AGE (In years<br>last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |                        |  |
| FEMALE   | WHITE   |   | NOV. 9, 1879     |   | 88 YRS.                             |   |  |                        |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH<br>Md.   |  |                        |  |
| WEST VIRGINIA  |         | U.S.A.  |                  |   |                                     | ALLEGANY  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                                     | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |                        |  |
| FROSTBURG  |         | MINERS HOSPITAL   |                  | HOUSE WORK  |                                     | OWN HOME  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |         | 13b. COUNTY   |                  | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| MARYLAND   |         | ALLEGANY  |                  | FROSTBURG   |                                     |   |  | ROUTE 1                |  |
| 14. FATHER'S NAME<br>First Middle Last   |         | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                   |                  |   |                                     |   |  |                        |  |
| HARRY C. SHIMER  |         | MARY D. AYERS   |                  |   |                                     |   |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)               |                  | 17. INFORMANT<br>Address  |                                     |   |  |                        |  |
|  |         | 220-52-9898   |                  | LOUIS ROSS, FROSTBURG, MD. RT 1   |                                     |   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Uremia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic nephrosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 month</u> |         |   |                  |   |                                     |   |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>446X</u>  |         |   |                  |   |                                     |   |  |                        |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |   |  |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                     |   |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1968</u> , to <u>Jan 17, 1968</u> , that (I) (we) last<br>saw the deceased alive on <u>Jan 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |         |   |                  |   |                                     |   |  |                        |  |
| 22b. SIGNATURE<br><u>A. Paige Strong</u>   |         | 22c. DATE SIGNED<br><u>Jan 17, 1968</u>   |                  | 22d. PHYSICIAN'S<br>NAME (Type)<br>A. PAIGE STRONG, M. D.   |                                     |   |  |                        |  |
| 22e. ADDRESS<br>E. MAIN ST., FROSTBURG, MD. 21532  |         |   |                  |   |                                     |   |  |                        |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         | 23b. DATE   |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)   |  |                        |  |
| BURIAL   |         | 1-17-68   |                  | F.B.G. MEMORIAL PARK  |                                     | FROSTBURG, MD.  |  |                        |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS  |         | 25a. REC'D BY REGISTRAR<br>DATE   |                  | 25b. REGISTRAR'S SIGNATURE  |                                     |   |  |                        |  |
| JOSEPH R. DURST, SR., FROSTBURG, MD. 21532   |         | JAN 22 1968   |                  | <u>Charles Judge</u>  |                                     |   |  |                        |  |

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RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00086

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00086

|   |  |   |  |   |   |   |   |  |  |
|---|--|---|--|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Beulah Edith Seaber</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>Jan</b> Day <b>7</b> Year <b>1968</b>                  |   |   | 2b. HOUR<br><b>7.30 PM</b>  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Jan. 21, 1887</b>  |   | 6. AGE (In years last birthday)<br><b>80</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>West Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Allegany</b> Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Westernport</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>405 Walnut</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Clerk</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cloth-Store</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Allegany</b>  |  | 13c. CITY OR TOWN<br><b>Westernport</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>405 Walnut</b>  |  |
| 14. FATHER'S NAME<br>First <b>Conrad</b> Middle <b>Fisher</b> Last <b></b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Elizabeth</b> Middle <b>L</b> Last <b>Kogel</b> |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>236-14-8020D</b>   |  | 17. INFORMANT<br>Address <b>William Seaber-Westernport, Md.</b>   |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>431.0</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Minutes</b><br><b>10 Years</b><br><b>10 Years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)<br><b>331X</b>  |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                 |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                         |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 20, 1968</b> , to <b>Jan 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec. 27, 1967</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Paul R. Wilson MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |  |   | 22c. DATE SIGNED<br><b>Jan 8, 1968</b>  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Paul R. Wilson</b>   |  |   |  |   | 22e. ADDRESS<br><b>Piedmont, W. Va.</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/10/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Philos</b>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Westernport Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>E. J. Kral</b> ADDRESS<br><b>Westernport, Md.</b>  |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                   |  |  |

4200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |   |   |  |  |  |           |
|---|--|--|--------------------------|---|---|--|--|--|-----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |   |   |  |  |  |           |
| CERTIFICATE OF DEATH  |  |  |                          |   |   |  |  |  |           |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last        |   |   | 2a. DATE OF DEATH  |  |  | 2b. HOUR  |
| Belle   |  |  | Carter                   |   |   | Jan. Month 28 Day 1968   |  |  | 5:30 P.M. |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |           |
| Female  |  | White  |                          | Oct. 31, 1881   |   | 86 YRS.  |  |  |           |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  | Md.  |           |
| Maryland  |  | USA  |                          |   |   | Allegany   |  |  |           |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |           |
| Oldtown   |  | Oldtown, Md.   |                          | Housewife   |   | Own Home   |  |  |           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |           |
| Maryland  |  | Allegany   |                          | Oldtown   |   |  |  | none   |           |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |   |   |  |  |  |           |
| First Middle Last   |  |  | First Middle Last        |   |   |  |  |  |           |
| Timothy H. Carter   |  |  | Loretta Brant            |   |   |  |  |  |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no   |  |  | 16b. SOCIAL SECURITY NO. |   | 17. INFORMANT Address   |  |  |  |           |
|   |  |  |                          |   | Mr. Clarence I. Shaw, Hagerstown, Md. Son   |  |  |  |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Virus Pharyngitis and Asian Influenza</u> |  |  |                          |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>2 hrs</u><br><u>10 days</u> |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>480X</u>  |  |  |                          |   |   |  |  |  |           |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |  |  |  |           |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |           |
|   |  |  |                          |   |   |  |  |  |           |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> , 19 <u>68</u> , to <u>4/28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |                          |   |   |  |  |  |           |
| 22b. SIGNATURE<br><u>Paul Jones DO.</u>   |  |  |                          |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>4/29/68</u>                                   |  |           |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Paul Jones, M.D.O.  |  |  |                          |   | 22e. ADDRESS<br>Paw Paw, W. Va.   |  |  |  |           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |           |
| Burial  |  | Jan. 30, 1968  |                          | Oldtown Cemetery  |   | Oldtown, Md. Allegany  |  |  |           |
| 24. FUNERAL DIRECTOR<br>James F. Scarpelli, Cumberland, Md.   |  |  |                          |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 1 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                   |  |           |

5390

*[Faint, illegible handwriting]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00088

00088

|  |  |   |   |   |   |   |   |   |   |        |      |
|--|--|---|---|---|---|---|---|---|---|--------|------|
| 1. DECEASED-NAME<br>(Type or print) <b>ROBERT</b>  |  |   | First   | Middle  | Lost  | 2a. DATE OF DEATH<br><b>JANUARY 4 1968</b>  |   |   | 2b. HOUR<br><b>7:10 P.M.</b>                            |        |      |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>                         |   | 5. DATE OF BIRTH<br><b>11-18-1887</b>   |   |   | 6. AGE (In years<br>lost birthday)<br><b>80</b> YRS.                            |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                |        |      |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>DELAWARE</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.                                       |   |   |        |      |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br><b>MEMORIAL HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Retired Engineer</b>                     |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Railroad</b> |        |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>MARYLAND</b> 3b. COUNTY <b>ALLEGANY</b>  |  |   | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>431 WILLIAM ST.</b>                                |   |   |        |      |
| 14. FATHER'S NAME<br><b>EDWARD</b>   |  |   | First   | Middle  | Lost  | 15. MOTHER'S MAIDEN NAME<br><b>MARY JANE GRIFFITH</b>   |   |   | First   | Middle | Lost |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) <b>no</b> (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.<br><b>705-10-1902</b>                                      |   | 17. INFORMANT<br>Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>                           |   |   |   |   |        |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b><br><b>410.9</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>3 yrs</b><br><b>5 yrs</b> |  |   |   |   |   |   |   |   |   |        |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |  |   |   |   |   |   |   |   |   |        |      |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |        |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |        |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)     |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |        |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>61</b> , to <b>Jan. 4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Jan 4</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |   |   |   |        |      |
| 22b. SIGNATURE<br><b>Clayton Durrett</b>   |  |   |   |   |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1/5/68</b>                                       |   |        |      |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. CLAY DURRETT</b>  |  |   |   |   |   | 22e. ADDRESS<br><b>CUMBERLAND, MD.</b>  |   |   |   |        |      |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Jan. 8, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>                               |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Md.</b> |   |   |        |      |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  |   |   |   |   | 25a. RECD BY REGISTRAR<br><b>JAN 10 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                      |   |        |      |

00028

ROBERT

SHORT

JANUARY 9 1950

WHITE

11-16-1987

NO

DELAWARE

U. S. A.

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

WARTLAND

ALLEGANY

CUMBERLAND X

WILLIAM ST.

EDWARD

SHORT

MARY

JANE

GRIFFITH

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. CLAY DUNNETT

CUMBERLAND, MD.

MAY 10 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M  
30M REV. 1-68

|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------------------|--|--|--|----------------------------|--|--|--|----------------|--|--|--|--|--|--|--|--|--|--|--|
| 00089   |  |  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                  |  |  |  |                                    |  |  |  |                            |  |  |  | 00089          |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First MIDDLE Last FRED ERICK SHUHART   |  |  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year JANUARY 3, 1968   |  |  |  |                                    |  |  |  |                            |  |  |  | 2b. HOUR 4:05A |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX MALE   |  |  |  | 4. RACE WHITE  |  |  |  | 5. DATE OF BIRTH 3-11-1891   |  |  |  | 6. AGE (In years last birthday) 76 YRS.  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS        |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) BARTON, MD.   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH ALLEGANY Md.  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 1d. CITY OR TOWN OF DEATH CUMBERLAND  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during life, work time, even if retired.)   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY MINING   |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.   |  |  |  | 13b. COUNTY ALLEGANY   |  |  |  | 13c. CITY OR TOWN BARTON   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER HIGH STREET |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First MIDDLE Last JOHN SHUHART  |  |  |  | 15. MOTHER'S MAIDEN NAME First MIDDLE Last NELLIE LEE  |  |  |  |  |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO. 215 10 4427   |  |  |  | 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.   |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 <u>Decompensation on the basis of a for advanced A.C.V.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>of a for advanced A.C.V.D.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-9-1967, to 1-3-1968, that (I) (we) last saw the deceased alive on 4:05AM 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Wm F. Williams   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED 1-4-68  |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS   |  |  |  | 22e. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD   |  |  |  |  |  |  |  |  |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL  |  |  |  | 23b. DATE 1/6/68   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL   |  |  |  | 23d. LOCATION (City or Town) (County) (State) MOSCOW MILLS ALLE. Md.                         |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR E. J. Boral  |  |  |  | ADDRESS WESTERNPORT, Md.   |  |  |  | 25a. REC'D BY REGISTRAR DATE JAN 8 1968  |  |  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |  |  |                                    |  |  |  |                            |  |  |  |                |  |  |  |  |  |  |  |  |  |  |  |

00084

FRED - MR

SHUMAT

JANUARY 3, 1908

WHITE

12-11-1901

75

BARTON, MD. USA

ALLERGY

CONSERVATION

MEMORIAL HOSPITAL

CONSERVATION

ALLERGY - FURTHER

HIGH STRESS

JOHN

SHUMAT

BELLE

191

12-11-1901

MEMORIAL HOSPITAL, CONSERVATION, MD.

4:00 PM

DR. W. F. WILLIAMS

12222 CENTRE ST., CHICAGO, ILL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

00090

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

00090

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>JOHN</b>  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 14, 1968</b>  |  |  | 2b. HOUR AM<br><b>9:05M</b>   |  |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br><b>9-8-82</b>   |  |  | 6. AGE (In years last birthday)<br><b>85</b> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SACRED HEART HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>B &amp; O SHOPS</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>MD.</b>  |  |  | 13b. COUNTY<br><b>ALLEGANY</b>   |  |  | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br><b>JAMES</b>  |  |  | First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>CATHERINE</b>  |  |  | First Middle Last<br><b>MINNICK</b>   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>705-05-4817</b>   |  |  | 17. INFORMANT<br><b>HOSPITAL RECORD</b>   |  |  | Address   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>ATHERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 YEARS</b>                                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221</b>   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5 - 27</b> , 19 <b>68</b> , to <b>1 - 14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Dr. R. W. Ballin</b>  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><b>1-15-68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. R. W. BALLIN</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>62 GREENE ST., CUMBERLAND, MD., 21502</b>  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>1/17/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Maryland</b>            |  |  |
| 24. FUNERAL DIRECTOR<br><b>H. Lee Silcox</b>   |  |  |  |  |  | ADDRESS<br><b>404 DECATUR ST., CUMB., MD</b>  |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 19 1968</b>   |  |  |
|  |  |  |  |  |  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |

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YOUNG

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ALLERBY.

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ALL INFORMATION CONTAINED



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23MAL

25 FEB 1964

2017/03/14

6.1

702-01-1417 HOSPITAL RECORD

OCT. 7. 1920

5 GREEN ST., CORNER 10, 15, 21503

STILCOX ENGINEER, 104 DEC TUR ST., CHICAGO, ILL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |   |  |  |  |
|---|--|--|--|--|---|---|--|--|--|
| Item 6 Film G397 1/24/68 kk   |  |  |  |  |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |
| JAMES   |  |  | H SMITH  |  |   | Month Day Year<br>JAN 9 68  |  |  | 8:15 A M   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |   | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| MALE  |  | WHITE  |  | 6-10-86  |   |   | 80 61 YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH   |  |  |
| MARYLAND  |  | U.S.A.   |  |  |   |   | ALLEGANY COUNTY Md.  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |
| CUMBERLAND  |  |  | MEMORIAL HOSPITAL  |  |   |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                                 |
| MARYLAND  |  |  | ALLEGANY   |  | FROSTBURG   |   |  |  | 112 HILL ST.   |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |   |  |  |  |
| LEWIS SMITH   |  |  | ROSE DRUMM   |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |   |  |  |  |
| NO  |  |  | 212-12-8753  |  | MEMORIAL HOSPITAL CUMBERLAND, MD.   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of rectosigmoidata</u><br>1540 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>154x</u><br>(b) _____ DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Since April '67</u> |  |  |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Bilateral emphysema &amp; Pulmonary fibrosis - C.D.C. U. Dis.</u>  |  |  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
|   |  |  |  |  |   |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |  |
|   |  |  |  |  |   |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |  |
|   |  |  |  |  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-11-1967</u> , to <u>1-9-1968</u> , that (I) <del>(we)</del> lost the deceased alive on <u>1-8-1968</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <u>(we)</u> did <u>(not)</u> view the body after death.  |  |  |  |  |   |   |  |  |  |
| 22b. SIGNATURE <u>W. F. Williams</u> DEGREE   |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED <u>1-9-68</u>   |  |  |
| 22d. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS   |  |  |  |  | 22e. ADDRESS CUMBERLAND, MD.  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| BURIAL  |  | 1-11-68  |  | ST. MICHAEL'S CEMETERY   |   |   | FROSTBURG, MD.   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE  |   | 25b. REGISTRAR'S SIGNATURE   |  |  |
| JOSEPH R. DURST, FROSTBURG, MD. 21532   |  |  |  |  | JAN 15 1968   |   | <u>Charles Judge</u>   |  |  |

00001

00001

11-8-88 2 JAN 2 WITH H JAMES

WHITE 6-10-88 20 1

ALLEGANY COUNTY 11-8-88

MEMORIAL HOSPITAL

12 HILL ST. BROOKING Y ALLEGANY

LEWIS SMITH ROSE

MEMORIAL HOSPITAL CHERRY AND

DR. W. F. WILLIAMS

1-11-88

1-11-88

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00092

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00092

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                  |  |  |   |                               |   |   |  |   |  |
|--|------------------|--|--|---|-------------------------------|---|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |                  |  | First  | Middle  | Last                          | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> Jan. 14, 1968 |   |  | 2b. HOUR <input type="checkbox"/> 7:30 <input type="checkbox"/> 8:00 <input type="checkbox"/> 9:00 <input type="checkbox"/> 10:00 <input type="checkbox"/> 11:00 <input type="checkbox"/> 12:00 |  |
| CORR   |                  |  | E.   | STEIN   |                               |   |   |  |   |  |
| 3. SEX<br>FEMALE   | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>JUNE 8, 1884   | 6. AGE (in years)<br>85 YRS.                                   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN. | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>January 14 1968   |   |  | 2d. HOUR <input type="checkbox"/> 7:30 <input type="checkbox"/> 8:00 <input type="checkbox"/> 9:00 <input type="checkbox"/> 10:00 <input type="checkbox"/> 11:00 <input type="checkbox"/> 12:00 |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               | 9. COUNTY OF DEATH<br>ALLEGANY  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br>613 BEDFORD STREET |  |   |                               | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWIFE                                |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME      |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |                  | 13b. COUNTY<br>ALLEGANY  |  | 13c. CITY OR TOWN<br>CUMBERLAND   |                               | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                     |   | 13e. STREET AND NUMBER<br>613 BEDFORD STREET       |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>FRANCIS DENNISON   |                  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>LETHA UNKNOWN |   |                               |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>NO  |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>NONE                          |  | 17. INFORMANT<br>ADDRESS<br>ARTHUR R. STEIN 613 BEDFORD ST., CUMBERLAND, MD.  |                               |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intra-abdominal Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Rupture of Arteriosclerotic Aortic Aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Minutes |                  |  |  |   |                               |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4518</u>  |                  |  |  |   |                               |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |   |                               |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                       |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                               |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                       |  | 21f. LOCATION Street or R.F.D. No.  |                               | City or Town  |   | County State                                       |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>          |                  |  |  |   |                               |   |   |  |   |  |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u>  |                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                |   |                               | 22b. DATE SIGNED  |   |  |   |  |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.   |                  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>    |   |                               | January 14, 1968  |   |  |   |  |
| ADDRESS (Street, city, town, or county) Cumberland, Maryland   |                  |  |  |   |                               |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |                  | 23b. DATE<br>JAN. 17, 1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ROSE HILL CEMETERY  |                               | 23d. LOCATION (City or Town) (County) (State)<br>CUMBERLAND, MD.  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>BYRON KIGHT  |                  |  |  | ADDRESS<br>CUMBERLAND, MD.  |                               | 25a. REC'D BY REGISTRAR<br>DATE JAN 19 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |   |  |

00000

WATER BARRIER CERTIFICATE OF ANALYSIS

00000

838 P. 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

00093

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00093

|  |  |  |       |   |                        |   |  |  |                                   |  |                     |
|--|--|--|-------|---|------------------------|---|--|--|-----------------------------------|--|---------------------|
| 1. DECEASED-NAME<br>(Type or print)<br><b>MARY</b>   |  |  | First | Middle<br><b>F.</b>   | Last<br><b>STEPPE</b>  | 2a. DATE OF DEATH<br>Month <b>JAN</b> Day <b>27</b> Year <b>68</b>                              |  |  | 2b. HOUR<br><b>10:25 P</b>        |  |                     |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |       | 5. DATE OF BIRTH<br><b>5-5-1905</b>   |                        | 6. AGE (In years last birthday)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                                    |                                   | IF UNDER 24 HRS.<br>HOURS<br>MIN.            |                     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                        | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.   |  |  |                                   |  |                     |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |       |   |                        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>ALLEGANY</b>   |       | 13c. CITY OR TOWN<br><b>CUMBERLAND</b>  |                        | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>21 MULLIN ST.</b>                       |                                   |  |                     |
| 14. FATHER'S NAME<br><b>EDWIN</b>  |  |  | First | Middle  | Last<br><b>HAWKINS</b> | 15. MOTHER'S MAIDEN NAME<br><b>MARY</b>   |  |  | First                             | Middle<br><b>E. (Hunt)</b>                   | Last<br><b>JUNT</b> |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |       | 17. INFORMANT<br>Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>   |                        |   |  |  |                                   |  |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4129 Congestive Heart Failure approx. 1 1/2 hrs.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4200</b><br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |       |   |                        |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hypertension Diabetes mellitus</b>   |  |  |       |   |                        |   |  |  |                                   |  |                     |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |       |   |                        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |                     |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                        |   |  |  |                                   |  |                     |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |       | 21f. LOCATION Street or R.F.D. No.  |                        | City or Town  |  | County   |                                   | State  |                     |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |       |   |                        |   |  |  |                                   |  |                     |
| 22b. SIGNATURE<br><b>John A. Toyner M.D.</b>   |  | DEGREE   |       | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |                        | 22c. DATE SIGNED<br><b>Jan 29, 1968</b>   |  |  |                                   |  |                     |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN A. TOYNER M.D.</b>   |  | I. C. DROSS, M.D.  |       | 22e. ADDRESS<br><b>456 N. CENTRE ST., CUMBERLAND, MD.</b>   |                        |   |  |  |                                   |  |                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><b>Jan. 31, 1968</b>  |       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |                        | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland, Allegany, Md.</b>               |  |  |                                   |  |                     |
| 24. FUNERAL DIRECTOR<br><b>James F. Scarpelli, Cumberland, Md.</b>   |  | ADDRESS  |       | 25a. REC'D BY REGISTRAR<br><b>FEB 2 1968</b>  |                        | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |                                   |  |                     |

00057

CERTIFICATE OF DEATH

00003

|            |         |            |       |          |             |    |      |
|------------|---------|------------|-------|----------|-------------|----|------|
| EDWIN      | HARRIS  | HARRY      | F.    | STEPRE   | JAN         | 27 | 1902 |
| WATYARD    | NEEDHAM | CUMBERLAND | WHITE | 5-2-1902 | 25          |    |      |
| CUMBERLAND | U.S.A.  | ALLIANCE   |       |          |             |    |      |
| WATYARD    | NEEDHAM | CUMBERLAND | X     | 21       | WILLIAM ST. |    |      |
| EDWIN      | HARRIS  | HARRY      | F.    | STEPRE   | JAN         | 27 | 1902 |
| WATYARD    | NEEDHAM | CUMBERLAND | WHITE | 5-2-1902 | 25          |    |      |
| CUMBERLAND | U.S.A.  | ALLIANCE   |       |          |             |    |      |
| WATYARD    | NEEDHAM | CUMBERLAND | X     | 21       | WILLIAM ST. |    |      |
| EDWIN      | HARRIS  | HARRY      | F.    | STEPRE   | JAN         | 27 | 1902 |

400 N. CENTRE ST., CUMBERLAND, MD.

100 N. CENTRE ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |                              |   |                  |  |   |   |   |
|--|------------------------------|---|------------------|--|---|---|---|
| 1. DECEASED-NAME<br>(Type or print)  |                              | First   | Middle           | Last   | 2a. DATE OF DEATH   |   | 2b. HOUR  |
| MAXINE   |                              | R   | X                | STROTHER   | 1-3-68<br>Month Day Year  |   | 10:40<br>A M  |
| 3. SEX   | 4. RACE                      |   | 5. DATE OF BIRTH |  | 6. AGE (In years<br>last birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                  |
| FEMALE   | WHITE                        |   | 3-24-20          |  | 47 YRS.   |   | IF UNDER 24 HRS.<br>HOURS MIN.                                  |
| 7a. BIRTHPLACE (State or foreign<br>country)   | 7b. CITIZEN OF WHAT COUNTRY? | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH   |   |   |   |
| ALMA, W.VA.  | U.S.A.                       |   |                  | ALLEGANY Md.   |   |   |   |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)   |                  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |   |
| CUMBERLAND   |                              | MEMORIAL HOSPITAL   |                  |  |   |   |   |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |                              | 13b. COUNTY   |                  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER  |   |
| W.VA.  |                              |   |                  | ROMNEY   |   | 485 W. BIRCH LANE   |   |
| 14. FATHER'S NAME  |                              | First   | Middle           | Last   | 15. MOTHER'S MAIDEN NAME  |   | First Middle Last   |
| LAWRENCE   |                              |   |                  | RIPLEY   | MARY  |   | E. BAKER  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |                              | 16b. SOCIAL SECURITY NO.  |                  | 17. INFORMANT  |   | Address   |   |
| No   |                              |   |                  | MEMORIAL HOSPITAL  |   | CUMBERLAND, MD.   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of the</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cystadenocarcinoma of right</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ovary</u>  |                              |   |                  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3 mo.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>1750</u>  |                              |   |                  |  |   |   |   |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |
| 9-2-67   |                              | Carcinoma right ovary   |                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |   |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State                               |   |   |   |
|  |                              |   |                  |  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-31</u> , 19 <u>67</u> , to <u>1-3</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>1-2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |                              |   |                  |  |   |   |   |
| 22b. SIGNATURE   |                              |   |                  | DEGREE   | ATTENDING<br>PHYS.  | MED.<br>DIRECTOR  | STAFF<br>PHYS.  |
| <u>DR. DONALD B. GROVE</u>   |                              |   |                  |  | <input type="checkbox"/>  | <input type="checkbox"/>  | <input type="checkbox"/>  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |                              |   |                  | 22e. ADDRESS   |   |   |   |
| DR. DONALD B. GROVE  |                              |   |                  | CUMBERLAND, MD.  |   |   |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |                              | 23b. DATE   |                  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)                           |   |
| Burial   |                              | Jan. 6, 1968  |                  | Indian Mound   |   | Romney Hampshire W.Va.  |   |
| 24. FUNERAL DIRECTOR   |                              |   |                  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |   |
| <u>Keith Shaffer</u>   |                              |   |                  | ADDRESS<br>Romney, W.Va.   |   | DATE<br>JAN 23 1968<br><u>Charles Judge</u>                             |   |

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DATE: 1-1-50 NAME: WHITE SEX: M RACE: WHITE

AGE: 31-35 HEIGHT: 5-10 WEIGHT: 150

EDUCATION: HIGH SCHOOL GRADUATE

EMPLOYMENT: UNEMPLOYED

RESIDENCE: 1234 5TH AVE. N. MINNAPOLIS, MINN.

DATE OF BIRTH: 1-1-1919

DATE OF DEATH: 1-1-1950

CAUSE OF DEATH: HEART DISEASE

PLACE OF DEATH: HOME

DATE OF BURIAL: 1-3-1950

PLACE OF BURIAL: CEMETERY

DATE OF INTERVIEW: 1-1-1950

INTERVIEWER: AGENT

DATE OF REPORT: 1-1-1950

REPORTER: AGENT

DATE OF REVIEW: 1-1-1950

REVIEWER: AGENT

DATE OF FINAL REPORT: 1-1-1950

FINAL REPORT: AGENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00095

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |         |  |        |   |   |   |                                |   |  |                                   |
|---|---------|--|--------|---|---|---|--------------------------------|---|--|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  | Middle | Lost  | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI-<br>DEATH MATED <input type="checkbox"/> |   | Month                          | Day   | Year                                       | 2b. HOUR                          |
| HENRY   |         |  |        |   | R. TALLEY (TALLEY)  |   | Jan.                           | 12  | 1968                                       | 9:30 AM                           |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN. |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |                                   |
| Male  | White   | Feb. 1, 1882   |        | 85 YRS.   |   |   |                                |   | Jan. 12 1968 9:30 AM                       |                                   |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |                                |   |  |                                   |
| W. Va.  |         | USA  |        | Allegany  |   |   |                                |   | Md.  |                                   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)         |        |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)             |   |                                | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                   |
| Cumberland  |         | Sacred Heart   |        |   | Retired Custodian   |   |                                | Church  |  |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |                                | 13e. STREET AND NUMBER  |  |                                   |
| Md.   |         | Allegany   |        | Cumberland  |   |   |                                | 313 Franklin St.  |  |                                   |
| 14. FATHER'S NAME   |         | First  | Middle | Lost  | 15. MOTHER'S MAIDEN NAME  |   | First                          | Middle  | Lost                                       |                                   |
| Stephen   |         |  |        |   | Ellen   |   |                                |   |  | Penn                              |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT ADDRESS   |   |   |                                |   |  |                                   |
| no  |         |  |        | Mrs. Mary Russell, Cumberland, Md. Daughter   |   |   |                                |   |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4129</u> Chronic Myocarditis<br>DUE TO, OR AS A CONSEQUENCE OF<br>Arteriosclerotic C V Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4321</u><br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Months<br>-- |         |  |        |   |   |   |                                |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Fell At Home Injuring Back--No Fractures  |         |  |        |   |   |   |                                |   |  |                                   |
| 19a. DATE OF OPERATION  |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |                                | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |         |  |        | 21b. TIME OF INJURY Month, Day, Year<br>HOURS AM PM<br>12:45 AM Jan. 12 1967  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Fell at home going to bathroom |                                |   |  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Home |        | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>313 Franklin St. Cumberland, Alleg. Md.   |   |   |                                |   |  |                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>               |         |  |        |   |   |   |                                |   |  |                                   |
| ACTUAL SIGNATURE<br><u>Benedict Skitarelic</u>  |         | EXAMINER'S NAME (Type)<br>Dr. Benedict Skitarelic, M.D.                              |        | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                         |  | 22b. DATE SIGNED<br>Jan. 12, 1968 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |         | 23b. DATE<br>Jan. 15, 1968   |        | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Mary's Cemetery   |   | 23d. LOCATION (City or Town) (County) (State)<br>Cumberland, Md. Allegany   |                                | 25a. REC'D BY REGISTRAR<br>DATE JAN 16 1968   |  |                                   |
| 24. FUNERAL DIRECTOR<br>James F. Scarpelli, Cumberland, Md.   |         | ADDRESS  |        | 25b. REGISTRAR'S SIGNATURE<br><u>James F. Scarpelli</u>   |   |   |                                |   |  |                                   |

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## CERTIFICATE OF DEATH

00096

00096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |   |   |  |  |  |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>RANDOLPH R TIPTON</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>JAN</b> Day <b>16</b> Year <b>68</b>     |   |   | 2b. HOUR<br><b>10:35A</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>3-26-05</b>  |   | 6. AGE (In years lost birthday)<br><b>62</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Auto shop foreman</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto</b>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>PA.</b>  |  | 13b. COUNTY<br><b>BEDFORD</b>  |  | 13c. CITY OR TOWN<br><b>HYNDMAN</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>BOX 372</b> |  |
| 14. FATHER'S NAME First Middle Lost<br><b>LUTHER M TIPTON</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Lost<br><b>EMMA B COUGHENOUR</b> |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown (If yes give war or dates of service)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>174-16-0156</b>   |  | 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>   |   | Address<br><b>CUMBERLAND, MD.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b><br><b>5718</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>uremia &amp; pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>year</b><br><b>weeks</b> |  |  |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>5810</b>  |  |  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 1, 1965</b> , to <b>July 16, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 16, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>DR. B. SCHINDLER</b>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>7/17/68</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. B. SCHINDLER</b>  |  |  |  | 22e. ADDRESS<br><b>CUMBERLAND, MD.</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Jan. 18, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hyndman Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Hyndman, Bedford Co., Pa.</b>               |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Harvey H. Zeigler, Hyndman, Pa.</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 22 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

00086

00086

RANDOLPH TIPTON JAN 16 1952

WIFE WHITE 2-28-105

PENNSYLVANIA U.S.A. X

CLIMBERLAND MEDICAL HOSPITAL

PA. BEDFORD HYPNOSIS BOX 322

TIPTON EVIDENCE CONCHERHONG

CLIMBERLAND, PA. 12-15-1952 MEDICAL HOSPITAL

DR. B. SCHWILKE CLIMBERLAND, PA.

Jan. 18, 1952 HYPNOSIS HOSPITAL, HANOVER, PA.

HANOVER, PA. HANOVER, PA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |   |   |   |   |  |
|---|--|--|---|---|---|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |   |   |   |   |  |
| CERTIFICATE OF DEATH  |  |  |   |   |   |   |   |   |  |
| 00097   |  |  |   |   |   |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND   |  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |   |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>   |  |  | c. LENGTH OF STAY IN 1b<br><u>1hr. + 15min.</u> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frostburg</u>  |   |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Sacred Heart Hospital</u>  |  |  |   |   | d. STREET ADDRESS<br><u>117 High St.</u>  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>George Samuel Truly</u>   |  |  |   |   | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>5</u> Year <u>1968</u>  |   |   |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>3/17/17</u>  |   | 9. AGE (In years lost birthday) yrs. <u>50</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Acetone Recovery</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Celanese Corp.</u>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Ocean, (or Lord), Md.</u>   |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>         |   |  |
| 13. FATHER'S NAME   |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>VIOLA WHETSTONE</u>  |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>YES W WAR II</u>   |  |  | 16. SOCIAL SECURITY NO.<br><u>217-10-1096</u>   |   | 17. INFORMANT<br><u>FROSTBURG, MD. 21532</u><br><u>MRS. GEORGE S. TRULY, 117 HIGH ST.</u>   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden coronary occlusion</u><br><u>4/10/68</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>coronary sclerosis</u> DUE TO<br>(c) <u></u> DUE TO |  |  |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 hours</u><br><u>2 years</u>                              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>4201</u>   |  |  |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3-1-</u> , 19 <u>67</u> , to <u>1-5-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-3-</u> , 19 <u>68</u> , and that death occurred at <u></u> M, from causes and on the date stated above.  |  |  |   |   |   |   |   |   |  |
| 22a. SIGNATURE<br><u>L. Brings</u>  |  |  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>             |   | 22b. DATE SIGNED<br><u>1-6-68</u>                     |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>LEWIS BRINGS, M.D.</u>   |  |  |   |   | 22d. ADDRESS<br><u>57 GREENE ST., CUMBERLAND, MD.</u>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  | 23b. DATE THEREOF<br><u>1/7/68</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>FROSTBURG MEM. PARK</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>FROSTBURG, MARYLAND</u> |   |   |  |
| 24. FUNERAL DIRECTOR<br><u>Marlou M. Sowers</u>   |  |  |   |   | 25a. REC'D BY REGISTRAR<br><u>HOME, 60 W. MAIN, FROSTBURG</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Jones</u> |   |  |
| JAN 11 1968   |  |  |   |   |   |   |   |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1968

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |                                    |  |  |  |  |
|---|--|--|--|---|------------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |                                    |  |  |  |  |
| 00098   |  |  |  |   | 00098                              |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |   | 2a. DATE OF DEATH                  |  |  | 2b. HOUR   |  |
| First Middle Last<br>JOAN MARIE TWIGG   |  |  |  |   | Month Day Year<br>JANUARY 19, 1968 |  |  | 4:45A M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |                                    | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  |
| FEMALE  |  | WHITE  |  | JUNE 25, 1946   |                                    | 21 YRS.  |  | MONTHS DAYS HOURS MIN.                                 |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH   |  |  |  |
| MARYLAND  |  | USA  |  |   |                                    | ALLEGANY Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                    | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| CUMBERLAND  |  | S ACRED HEART HOSP.  |  | HOUSEWIFE   |                                    |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |                                    | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                                 |  |
| MARYLAND  |  | ALLEGANY   |  | LA VALE   |                                    |  |  | 3 CLUB HOUSE ROAD                                      |  |
| 14. FATHER'S NAME First Middle Last   |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |                                    |  |  |  |  |
| STANLEY H. HARMAN   |  | MARY ELIZABETH CARWELL   |  |   |                                    |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no or unknown) NO  |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               |  | 17. INFORMANT Address   |                                    |  |  |  |  |
|   |  | 213-48-6541  |  | HOSPITAL RECORD   |                                    |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of ovaries</u><br>1830 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |                                    |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 year |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>1750  |  |  |  |   |                                    |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
| Feb 67  |  |  |  |   |                                    |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                    |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                    |  |  |  |  |
|   |  |  |  |   |                                    |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-3, 1967, to 1-19, 1968, that (I) (we) last saw the deceased alive on 1-18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                                    |  |  |  |  |
| 22b. SIGNATURE <u>H. Brings</u>   |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |                                    | 22c. DATE SIGNED 1-19-68   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.   |  |  |  | 22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD.   |                                    |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                    | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| BURIAL  |  | 1/22/1968  |  | RESTLAWN MEMORIAL GARDENS   |                                    | LA VALE, ALLEGANY, MARYLAND  |  |  |  |
| 24. FUNERAL DIRECTOR JOHN J. HAFFER, JR. 230 BALTO. AVE. CUMB., MD.   |  |  |  | 25a. REC'D BY REGISTRAR DATE JAN 24 1968  |                                    | 25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>  |  |  |  |

22000

2404

DATE: 06-01-78 BY: JACOB L. WHITE

ALLEGANY

CONFIDENTIAL 2 ALBERT HEAT 102011 11/11/2011

213-6-5411      11-2-61

LEWIS & CLARK, M.O. 577, CLARK ST., CHICAGO, ILL.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00099

CERTIFICATE OF DEATH

00099

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  | c. LENGTH OF STAY IN 1b<br><b>8 DAYS</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SACRED HEART HOSPITAL</b>   |  | d. STREET ADDRESS<br><b>ROUTE # 1</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CONNIE</b> Middle <b>L.</b> Last <b>WALTER</b>   |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>3</b> Year <b>19 68</b>   |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DECEMBER 12, 1954</b>   |
| 9. AGE (In years lost birthday)<br><b>13 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HRS.<br>Hours _____ Min. _____   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Flintstone High</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>ALLEGANY, MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>ARTHUR WALTER</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ORPHA KEEFER</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>213-48-5930</b>   |  |
| 17. INFORMANT<br><b>HOSPITAL RECORD</b>  |  | Address _____   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>2730</b><br>DUE TO <b>cystic fibrosis of the pancreas</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) _____<br>(c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>2893</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> , 19 <b>68</b> to <b>1/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12</b> , 19 <b>68</b> , and that death occurred at <b>5:00</b> A.M. from causes and on the date stated above.                                  |  |   |  |
| 22a. SIGNATURE<br><b>Elizabeth Brings</b>  |  | 22b. DATE SIGNED<br><b>1/4/68</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ELIZABETH BRINGS, M.D.</b>  |  | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1/ 5/1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Near Chaneyville Bedford. Pa</b> |
| 24. FUNERAL DIRECTOR<br><b>John J. Hafer, Jr.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 5 1968</b>  |  |
| ADDRESS<br><b>230 Balto Ave. Cumberland</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>   |  |

00033

ESTIMATE OF DEATH

00033

ALLEGANY

HARYLAND

ALLEGANY

CUMBERLAND

8 DAYS

FLINTSTONE

SACKED HEART HOSPITAL

ROUTE W. 1

CONNIE

L.

WALTER

JANUARY 3

80

FEMALE WHITE

DECEMBER 1, 1924 13

ARTHUR WALTER

CLIFF KEEPER

NO

HOSPITAL RECORD

ALLEGANY, HARYLAND

USA

ELIZABETH BRINGS, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |  |   |  |                                      |  |  |                                       |  |  |
|---|--|--|--|--|--|--|--|---|--|---|--|--------------------------------------|--|--|---------------------------------------|--|--|
| 00100   |  |  |  |  | CERTIFICATE OF DEATH   |  |  |   |  | 00100   |  |                                      |  |  |                                       |  |  |
| 1. DECEASED NAME (Type or print) <b>ROBERT</b> <sup>First</sup> <b>GREGG</b> <sup>Middle</sup> <b>WEAVER</b> <sup>Last</sup>  |  |  |  |  | 2a. DATE OF DEATH <b>JANUARY</b> <sup>Month</sup> <b>22</b> <sup>Day</sup> <b>68</b> <sup>Year</sup> |  |  |   |  | 2b. HOUR <b>8:00</b>  |  |                                      |  |  |                                       |  |  |
| 3. SEX <b>MALE</b>  |  |  | 4. RACE <b>WHITE</b>   |  |  | 5. DATE OF BIRTH <b>1-7-68</b>   |  |   | 6. AGE (In years last birthday) <b>16</b> <sup>YRS.</sup>            |   |  | IF UNDER 1 YEAR MONTHS <b>16</b>     |  |  | IF UNDER 24 HRS. HOURS <b>16</b> MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>ALLEGANY</b>                                 |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH <b>ALLEGANY</b> <sup>Md.</sup>                    |   |  |                                      |  |  |                                       |  |  |
| 10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |                                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD.</b>  |  |  |  | 13b. COUNTY <b>ALLEGANY</b>  |  |  |  | 13c. CITY OR TOWN <b>BARTON</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>BOX 91</b> |  |  |                                       |  |  |
| 14. FATHER'S NAME <b>ROBERT</b> <sup>First</sup> <b>WEAVER</b> <sup>Middle</sup> <b>DIXIE</b> <sup>Last</sup>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME <b>HOWELL</b> <sup>First</sup> <b>HOWELL</b> <sup>Middle</sup>              |  |  |   |  |   |  |                                      |  |  |                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO. <b>0</b>  |  | 17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b> <sup>Address</sup>   |  |   |  |   |  |                                      |  |  |                                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Meningitis caused by <i>Streptococcus</i></b><br><b>482.9</b> DUE TO, OR AS A CONSEQUENCE OF <b>Bilateral Pneumonia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |   |  |   |  |                                      |  |  |                                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>490.8</b>   |  |  |  |  |  |  |  |   |  |   |  |                                      |  |  |                                       |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |                                      |  |  |                                       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.                  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |                                      |  |  |                                       |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |                                      |  |  |                                       |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |   |  |                                      |  |  |                                       |  |  |
| 22b. SIGNATURE <b>Dr. Abdul S. Hashim</b>   |  |  | DEGREE <b>MD.</b>  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     |  |   | 22c. DATE SIGNED <b>1/23/68</b>                                      |   |  |                                      |  |  |                                       |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>DR. ABDUL S. HASHIM</b>   |  |  | 22e. ADDRESS <b>LA VALE, MD.</b>   |  |  |  |  |   |  |   |  |                                      |  |  |                                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  | 23b. DATE <b>1/24/68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>   |  |   | 23d. LOCATION (City or Town) (County) (State) <b>Moscow Mills Md</b> |   |  |                                      |  |  |                                       |  |  |
| 24. FUNERAL DIRECTOR <b>E.L. Bral</b>   |  |  | ADDRESS <b>Westernport, Md.</b>  |  |  | 25a. REC'D BY REGISTRAR <b>JAN 29 1968</b> DATE  |  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                      |   |  |                                      |  |  |                                       |  |  |

00100

00100

ROBERT

GREEN

WEAVER

JANUARY

22 00

MALE

WHITE

1-2-58

ALLEGANY

ALLEGANY

CUMBERLAND

HOSPITAL

MD.

ALLEGANY

BARTON

BOX 21

ROBERT

WEAVER

DIXIE

NEWELL

EXPERIMENTAL HOSPITAL, CUMBERLAND, MD.

DR. ROBERT S. HASTIN

TRAVEL, E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00101

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

00101

|   |                  |  |   |   |  |
|---|------------------|--|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>LOGAN MARKLE WERT  |                  |  | 2a. DATE OF DEATH<br>Month Day Year<br>JANUARY 27 1968  |   | 2b. HOUR<br>4:00AM                             |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE |  | 5. DATE OF BIRTH<br>JUNE 27, 1921   |   | 6. AGE (In years last birthday)<br>46 YRS.     |
| 7a. BIRTHPLACE (State or foreign country)<br>PENNSYLVANIA   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>ALLEGANY Md.             |
| 10. CITY OR TOWN OF DEATH<br>CUMBERLAND, MD.  |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>SACRED HEART HOSP. |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>CONTRACTOR |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.  |                  | 13b. COUNTY<br>ALLEGANY  | 13c. CITY OR TOWN<br>CUMBERLAND   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       | 13e. STREET AND NUMBER<br>222 WILLS CREEK AVE. |
| 14. FATHER'S NAME First Middle Last<br>LOGAN M. WERT  |                  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>ELIZABETH WRAY  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, <input checked="" type="checkbox"/> (If yes give war or dates of service)<br>W. W. # 2   |                  | 16b. SOCIAL SECURITY NO.<br>173-16-3980  |   | 17. INFORMANT Mrs. Logan M. Wert Address<br>HOSPITAL RECORD 222 Wills Creek Ave. Cumb. Md.            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Ca - Kneecaps</u><br>1890 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1808</u><br>(b) <u>Renal Tumor - Malignant</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>5 months</u><br><u>12 months</u> |                  |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Cachexia</u>   |                  |  |   |   |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |                  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><u>N/A</u>         |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-29, 1967</u> , to <u>1-27, 1968</u> , that (I) (we) last saw the deceased alive on <u>1-25, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                  |  |   |   |  |
| 22b. SIGNATURE<br><u>William R. Wolverton</u>   |                  | 22c. DATE SIGNED<br><u>1-27-68</u>   |   | 22d. PHYSICIAN'S NAME (Type)<br>WILLIAM R. WOLVERTON, M.D.  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                  | 23b. DATE<br><u>1/29/68</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Sunset Memorial Park</u>                                     |  |
| 24. FUNERAL DIRECTOR<br><u>H. Wayne George</u>  |                  | ADDRESS<br><u>Cumberland, Md.</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 30 1968</u>  |  |
|   |                  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

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WILLIAM E. HOLZNER, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 only should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|--|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |  |  |   |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |   |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>CHARLES</b>  |  | Middle<br><b>M.</b>   |  | Last<br><b>WILSON</b>  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>JAN. 16 68</b>  |  |  | 2b. HOUR<br><b>8:06</b>   |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>3-12-81</b>  |  |  | 6. AGE (In years lost birthday)<br><b>86</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS                 |  | IF UNDER 24 HRS.<br>HOURS MIN   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>KITZMILLER, MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>ALLEGANY</b> Md.  |   |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>CUMBERLAND</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MEMORIAL HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Employee-Cumb Steel Co.</b>      |  |   | 12b. KIND OF BUSINESS OR INDUSTRY              |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Allegany</b>   |   |  | 13c. CITY OR TOWN<br><b>Cumberland</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 13e. STREET AND NUMBER<br><b>66 Marion Street</b>              |   |
| 14. FATHER'S NAME First Middle Last<br><b>JEROME WILSON</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>EMILY MAY TICE</b>                                      |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)                  |  |   | 16b. SOCIAL SECURITY NO.<br><b>214-05-7777</b> |  | 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b> Address<br><b>CUMBERLAND, MD.</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lobar Pneumonia--Auto Viral Influenza</b><br><b>471x</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>with Gastroenteritis</b><br>(b) <b>Anemia-Marked Secondary</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cerebral Vascular Accident due to</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>480x</b><br><b>Arteriosclerotic</b> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 weeks</b> |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 <b>67</b> , to <b>Jan. 15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Jan. 15</b> , 19 <b>67</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |  |   |
| 22b. SIGNATURE<br>   |  |  |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>1-17-68</b>  |  |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DR. G. O. HIMMELWRIGHT</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>CUMBERLAND, MD.</b>   |  |   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>1/19/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cumberland Allegany Maryland</b> |   |  |  |   |
| 24. FUNERAL DIRECTOR<br><b>H. Lee Silcox</b> <b>Cumberland, Maryland 21502</b>  |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 22 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |   |

MEDICAL CERTIFICATION

00102

00102

JAN 18 1958

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CHARLES

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MEMORIAL HOSPITAL

CHICAGO, ILL.

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MEMORIAL HOSPITAL

RECEIVED O. S. A.

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RECEIVED O. S. A.

JAN 18 1958

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00103

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00103

|   |         |  |        |  |                            |  |                                |  |                               |  |
|---|---------|--|--------|--|----------------------------|--|--------------------------------|--|-------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         | First  | Middle | Last   | 2a. DATE KNOWN<br>OF DEATH |  | <input type="checkbox"/> Month | <input type="checkbox"/> Day   | <input type="checkbox"/> Year | 2b. HOUR                                     |
| JOHN WALTER WINEBRENNER, JR.  |         |  |        |  | JAN. 17 1968               |  |                                |  |                               | 3:30 PM                                      |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR            |  | IF UNDER 24 HRS                |  | 2c. DATE PRONOUNCED DEAD      |  |
| MALE  | WHITE   | AUG. 9, 1930   |        | 37 YRS.  | MONTHS DAYS                |  | HOURS MIN.                     |  | Jan. 17 1968 3:30             |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. COUNTY OF DEATH   |                                |  |                               |  |
| MARYLAND  |         | U.S.A.   |        |  |                            | ALLEGANY Md.   |                                |  |                               |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life or retired.)  |                            | 12b. KIND OF BUSINESS OR INDUSTRY  |                                |  |                               |  |
| FROSTBURG   |         | D O A MINERS HOSPITAL  |        | PIPE FITTER  |                            | B&O R.R.   |                                |  |                               |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                            | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                | 13e. STREET AND NUMBER   |                               |  |
| MARYLAND  |         | ALLEGANY   |        | MT. SAVAGE   |                            |  |                                | RURAL  |                               |  |
| 14. FATHER'S NAME   |         | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME   |  | First                          | Middle   | Last                          |  |
| JOHN WALTER WINEBRENNER   |         |  |        |  | VIRGINIA GORDON            |  |                                |  |                               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |                            | ADDRESS  |                                |  |                               |  |
|   |         | 217-28-9871  |        | MRS. MARLENE W. WINEBRENNER, MT. SAVAGE, MD.   |                            | BOX 582,   |                                |  |                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |        |  |                            |  |                                |  |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |         |  |        |  |                            |  |                                |  |                               |  |
| IMMEDIATE CAUSE (a) Coronary Occlusion  |         |  |        |  |                            |  |                                |  |                               | Sudden                                       |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |        |  |                            |  |                                |  |                               |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |         |  |        |  |                            |  |                                |  |                               |  |
| (b) Coronary Sclerosis  |         |  |        |  |                            |  |                                |  |                               | ---  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |        |  |                            |  |                                |  |                               |  |
| (c)   |         |  |        |  |                            |  |                                |  |                               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |        |  |                            |  |                                |  |                               |  |
| 430   |         |  |        |  |                            |  |                                |  |                               |  |
| 19a. DATE OF OPERATION  |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                            |  |                                | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY Month, Day, Year   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                            |  |                                |  |                               |  |
|   |         | HOUR A.M. P.M. 19  |        |  |                            |  |                                |  |                               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                            |  |                                |  |                               |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |        |  |                            |  |                                |  |                               |  |
| ACTUAL SIGNATURE  |         | Benedict Skitarelis M.D.   |        |  |                            | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                | 22b. DATE SIGNED   |                               |  |
| EXAMINER'S NAME (Type)  |         | BENEDICT SKITARELIS, M. D.   |        |  |                            | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |                                | January 17, 1968   |                               |  |
|   |         |  |        |  |                            | ADDRESS (Street, city, town, or county)  |                                | RD 9, Cumberland, Md.  |                               |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                            | 23d. LOCATION (City or Town) (County) (State)  |                                |  |                               |  |
| BURIAL  |         | JAN. 21, 1968  |        | METHODIST CEMETERY   |                            | MT. SAVAGE, MD.  |                                |  |                               |  |
| 24. FUNERAL DIRECTOR  |         |  |        | ADDRESS  |                            | 25a. REC'D BY REGISTRAR  |                                | 25b. REGISTRAR'S SIGNATURE   |                               |  |
| JOSEPH R. DURST, FROSTBURG, MD. 21532   |         |  |        |  |                            | DATE JAN 22 1968   |                                | J Charles Judge  |                               |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |         |  |                  |  |   |  |  |  |
|--|--|---------|--|------------------|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |         |  |                  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |         |  |                  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |         | First Middle Last  |                  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                                     |
| J. Edwin Winters   |  |         |  |                  |  | Jan, 27th, 1968   |  |  | M  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.              |  |
| Male   |  | White   |  | 4/21/1899        |  | 68 YRS.   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  |
| Pa.  |  |         | USA  |                  |  |   | Allegany Md.   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Midland  |  |         | Paradise Street  |                  |  | Retired Bank Employee   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |
| Md.  |  |         | Allegany   |                  | Midland  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | Paradise St.                                 |
| 14. FATHER'S NAME First Middle Last  |  |         | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |                  |  |   |  |  |  |
| ----- Winters  |  |         | Ella Lancaster   |                  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |         | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT Address  |   |  |  |  |
| No   |  |         | 215-18-8092  |                  | Alma Winters Midland, Md.  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>   |  |         |  |                  |  |   |  |  | 20 min.                                      |
| 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Insufficiency</u>  |  |         |  |                  |  |   |  |  | 5 years                                      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>   |  |         |  |                  |  |   |  |  | years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |         |  |                  |  |   |  |  |  |
| 4201   |  |         |  |                  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|  |  |         |  |                  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |
|  |  |         |  |                  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |
|  |  |         |  |                  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1968</u> , 19 <u>63</u> to <u>Jan 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>Jan 15, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |  |                  |  |   |  |  |  |
| 22b. SIGNATURE <u>[Signature]</u> MD DEGREE  |  |         |  |                  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <u>1.29.68</u>                                      |  |
| 22d. PHYSICIAN'S NAME (Type) <u>L.R. MILES, JR. M.D.</u>   |  |         |  |                  |  | 22e. ADDRESS <u>LONA CONING MD 21539</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial   |  |         | 1/30/1968  |                  | St. Michaels Cemetery  |   | Frostburg, Md.   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |         |  |                  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| George Eichhorn Lonaconing, Md.  |  |         |  |                  |  | DATE <u>JAN 31 1968</u>   |  | <u>[Signature]</u>   |  |

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REPUBLIC OF CHINA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 00105  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 00105  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                                     |  |
| First  |  | Middle   |  | Last   |  | Jan. Month 24, Day 68 Year   |  | 3:45 A. M.                                   |  |
| William  |  | Carl   |  | Zais   |  |  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR                              |  |
| Male   |  | White  |  | 7/18/1903  |  | 64 YRS.  |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| Maryland   |  | U. S. A.   |  |  |  | Allegany Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Cumberland,  |  | 129 Paca St.   |  | Machinist  |  | Celanese Silk  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| Maryland   |  | Allegany   |  | Cumberland   |  |  |  | 129 Paca St.                                 |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |
| First Middle Last  |  | First Middle Last  |  |  |  |  |  |  |  |
| John F. Zais   |  | Susan M. Patrick   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No   |  | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service)               |  | 17. INFORMANT  |  | Address  |  |  |  |
|  |  | 214-07-3502  |  | Mrs. Elizabeth Zais  |  | 129 Paca St. Cumb. Md.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 1621   |  |  |  |  |  |  |  | 3 months                                     |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1638  |  |  |  |  |  |  |  | 3 months                                     |  |
| (b) Carcinoma of the Lungs   |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |
| Pulmonary Emphysema & Fibrosis   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 29, 1967, to 1/29/1968, that (I) (we) lost the deceased alive on 1/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |
| S. G. Weisman, M. D.   |  | 1/25/68  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
|  |  | 59 Greene St Cumberland, Md.   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| Burial   |  | 1/27/68  |  | Sunset Memorial Park   |  | Cumberland, Allegany Md.   |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| H. Wayne George  |  | Cumberland, Maryland   |  | DATE JAN 30 1968   |  | Charles Judge  |  |  |  |

00100

00100

CLASSIFICATION OF DATA

UNITED STATES DEPARTMENT OF COMMERCE

|                        |  |                          |  |
|------------------------|--|--------------------------|--|
| 1. NAME OF THE FIRM    |  | 2. ADDRESS               |  |
| 3. CITY                |  | 4. STATE                 |  |
| 5. ZIP CODE            |  | 6. PHONE NUMBER          |  |
| 7. TYPE OF BUSINESS    |  | 8. DATE OF ESTABLISHMENT |  |
| 9. NUMBER OF EMPLOYEES |  | 10. YEAR OF FOUNDED      |  |
| 11. TYPE OF PRODUCT    |  | 12. YEAR OF FOUNDED      |  |
| 13. TYPE OF PRODUCT    |  | 14. YEAR OF FOUNDED      |  |
| 15. TYPE OF PRODUCT    |  | 16. YEAR OF FOUNDED      |  |
| 17. TYPE OF PRODUCT    |  | 18. YEAR OF FOUNDED      |  |
| 19. TYPE OF PRODUCT    |  | 20. YEAR OF FOUNDED      |  |
| 21. TYPE OF PRODUCT    |  | 22. YEAR OF FOUNDED      |  |
| 23. TYPE OF PRODUCT    |  | 24. YEAR OF FOUNDED      |  |
| 25. TYPE OF PRODUCT    |  | 26. YEAR OF FOUNDED      |  |
| 27. TYPE OF PRODUCT    |  | 28. YEAR OF FOUNDED      |  |
| 29. TYPE OF PRODUCT    |  | 30. YEAR OF FOUNDED      |  |
| 31. TYPE OF PRODUCT    |  | 32. YEAR OF FOUNDED      |  |
| 33. TYPE OF PRODUCT    |  | 34. YEAR OF FOUNDED      |  |
| 35. TYPE OF PRODUCT    |  | 36. YEAR OF FOUNDED      |  |
| 37. TYPE OF PRODUCT    |  | 38. YEAR OF FOUNDED      |  |
| 39. TYPE OF PRODUCT    |  | 40. YEAR OF FOUNDED      |  |
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| 43. TYPE OF PRODUCT    |  | 44. YEAR OF FOUNDED      |  |
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| 49. TYPE OF PRODUCT    |  | 50. YEAR OF FOUNDED      |  |
| 51. TYPE OF PRODUCT    |  | 52. YEAR OF FOUNDED      |  |
| 53. TYPE OF PRODUCT    |  | 54. YEAR OF FOUNDED      |  |
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| 95. TYPE OF PRODUCT    |  | 96. YEAR OF FOUNDED      |  |
| 97. TYPE OF PRODUCT    |  | 98. YEAR OF FOUNDED      |  |
| 99. TYPE OF PRODUCT    |  | 100. YEAR OF FOUNDED     |  |